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ABSTRACT

The National Education Association (NEA) Retirement and Benefits Forum is an annual event where leaders, lobbyists, researchers, and trustees of retirement and health and welfare plans meet to learn about and discuss current and future retirement and benefits issues. This report of the 1990 forum contains 10 selected papers and a welcoming speech by Robert F. Chase, vice president of the NEA, who discussed the importance of retirement and benefits issues. Three sections follow this introduction. The first is entitled "Three Critical Issues" and includes three papers: (1) "Pensions and Benefits in the 1990s: Challenges and Opportunities for Public Education Employees" (Dallas Salisbury); (2) "Funding Issues for Public Retirement and Retiree Health Plans" (Sophie M. Korczyk); and (3) "The New Medicare Physician Reimbursement Schedule" (L. Maynard Oss). The second section covers state health plans and also includes three speeches: (1) "The Hawaii Plan" (Marylin Matsunaga); (2) "The New York Proposal" (Dan Beauchamp); and (3) "The Ohio Proposal" (Dennis Roberge). The last section contains four papers that focus on proposals for a national health plan: (1) "The Physicians Proposal" (Steffie Woolhandler); (2) "Tax Reform Model" (Edmund Haislmaier); (3) "A Genuine National Health Insurance Plan" (William Glaser); and (4) "Health Care Reform: The Buy Right Strategy" (Walter McClure). (LAP)

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NEA RETIREMENT AND BENEFITS FORUM: SELECTED PROCEEDINGS

Clearwater Beach, Florida, October 18-21, 1990

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Acknowledgments

The NEA Retirement and Benefits Forum is an annual event of the Association during which leaders, lobbyists, researchers, and trustees of retirement and health and welfare plans meet to learn about and discuss current and future retirement and benefits issues.

One feature of the forum is its relevance to participants. Throughout the year people talk about the forum, quote its speakers, and refer to shared information. They draw upon the forum experience as they work to strengthen retirement plans and health care benefits in their states.

Many people helped to make the 1990 forum a successful event. While these proceedings capture only those topics that will be of interest to the broadest range of readers, we do want to thank all the forum speakers, whose insights, expertise, and experience contributed to our understanding of issues in the field:

Dan E. Beauchamp, New York State Department of Health

Vade D. Bolton, National Education Association

Robert F. Chase, Vice President of the National Education Association

William Crist, California Faculty Association

Michael D. Edwards, National Education Association

Cathie G. Eitelberg, Government Finance Officers Association

Roberta Feinstein Havel, Save Our Security Coalition

Bruce Hineman, Teacher Retirement System of Texas

Ed Friend, Ed Friend, Inc.

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Penelope S. Wardlow, Governmental Accounting Standards Board

Stephanie J. Woolhandler, Harvard Medical School

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Welcome—
The Importance of Retirement and Benefits Issues to the NEA

Robert F. Chase, Vice President, National Education Association

I am delighted to have the opportunity to spend a few moments talking with you about retirement, about benefits, and about the importance of these issues to the more than two million members of our Association and their families. Most of our members will experience an illness during the next 5 years. Many of them will retire within the next 10 years. All of them are greatly concerned about their futures in regard to these issues.

Importance of the Forum and the Issues It Addresses

This NEA forum is unique in that it does not examine salaries and benefits in a vacuum, but places them in the broader context of the most current and critical legislative and economic initiatives emanating from the federal and the state levels of government. While addressing these issues from a membership perspective, this forum also gives us the opportunity to hear the experts — the creative thinkers — and to formulate ideas of our own, which we can share with colleagues from other states and colleagues back home.

Retirement and health benefits affect not only every NEA member, but every aspect of the NEA and of the education profession. They affect the quality of the education our nation's students receive. They affect our legislative, collective bargaining, and compensation programs. Rae Grad, executive director of the National Commission to Prevent Infant Mortality, said recently, "You can't educate a child unless all systems — brain cells, eyes, ears — are go." By the same token, you can't expect education employees to provide the quality education they want and need to provide if all the systems that support them and their families are not fully operational.

Threats to Retirement and Benefits Packages

All across our nation, retired education employees are looking at their retirement packages with trepidation because of fiscal woes that show no sign of relenting. Indeed, the road to solid health benefits and secure retirement is rockier than ever for America's education employees and for Americans across the board. In the case of retirement benefits, for example, between now and the turn of the century nearly 50,000 teachers will retire each year. From 2001 to 2010, that number is projected to reach more than 70,000 per year. How can we attract and maintain new and excellent teachers and new and excellent support staff for our nation's schools if we do not pay them a competitive salary and provide them with an adequate benefits package that meets the needs of the future?

What kind of retirement can citizens who staffed our schools have if they are constantly forced to look over their shoulders at the menace of the diminishing value of

their benefits? But look over their shoulders is exactly what education employees must do because their pension plans are inadequate. Their pension plans are being raided by state and local governments to offset budget deficits. Their pension plans will not sustain them in their later years if this practice continues. Indeed, this funding practice threatens to destroy the future economic security of our nation's education employees, and the consequences are clear. In the final analysis, reductions in benefits for education employees and their families will only translate into reductions in the quality of education we provide our nation's young people.

As of this school year, 12 states have delayed, deferred, or simply failed to make contributions to members' pension plans. Seven of these states were delinquent in making their pension contributions during the last five years. To compound matters, the federal government is now making changes in the Internal Revenue Code that might impose limits on the retirement benefits a member can receive and an employer may be obligated to contribute. Consequently the anxieties are mounting and the concerns are increasing for American education employees near retirement everywhere.

In the case of health benefits, the challenge we face is also great. Health care costs in the United States rose to nearly $650 billion in 1989 — almost 12 percent of our gross national product (GNP). By contrast, only 6 percent of our GNP went toward public education. Health care premium costs for our members are rising at an average of 20 to 25 percent per year, four to five times the rate of inflation. The result is that health care is rapidly becoming unaffordable for public education employees and their families.

Shouldering the Costs

I do not intend to ignore the fact that approximately 37 million U.S. citizens have no health insurance protection whatsoever, and those who do have health insurance —through their employer, through Medicare, or through Medicaid — are paying a disproportionate share of the total health care tab for everyone. To exacerbate the situation, employers and health care providers, in a trend that is growing, are trying to shift more of their health cost burdens to individual workers. Indeed, individual Americans are paying a substantially higher percentage of health care costs. In many businesses and industries, the shouldering of the costs of health care benefits by workers amounts to an across-the-board salary cut for those who can least afford it: the average American workers. More dollars spent for health care means fewer dollars spent on their families.

For education employees this assault on benefits is no less severe. Because of cost containment measures, because of prevailing managed care programs, and because of efforts that force education employees to shoulder increasing portions of the costs for health care, their benefits are being eroded as are the benefits of their counterparts in the labor movement. In 1987, for example, only one of eight educators was required to pay a part of his or her health premium. Today one of three educators is required to do so.

Spiraling health care premiums are also affecting contract negotiations between school districts and education employees. Too often these days the escalating costs of health care premiums are forcing school employees at the bargaining table to choose between improving their salaries and maintaining adequate health insurance protection for their families. No American workers, particularly an education employee whose salary in most cases is already too low, should have to choose between making a basic, living wage and maintaining health benefits for the family.

Ultimately our nation will have to pay for this choice. Health care premium increases, even when inflation is factored out, are actually depressing salaries for education employees currently working in our schools. Because more school revenues are going toward increased premiums for health care, fewer revenues are available for salary increases and programs for our students.

We desperately need salary increases to attract the very best minds available to the teaching profession. If our nation is to compete successfully in the global economy of the future, our nation's schools need those "best minds" as part of the teaching force. Spiraling health costs are preventing us from achieving the kind of educational excellence we all want in our schools.

Responses of the Federal Government

Rather than helping to make things better, once again the federal government has actually entertained legislation that would make matters worse. Over the past five years, some of our national legislators have attempted to introduce what I call "Frankenstein legislation." Nothing could be more of a horror show, more perverse, and more harmful to the economic health of workers than the effort by some legislators to tax employee benefits. Such legislation is not only obscene, it should be x-rated. No adult should be allowed to see it. No adult should experience it, and no child should know it ever existed. Nevertheless, because of the current budget imbroglio and fiscal folly, such legislative

proposals may again be on the table.

Of course, no one wants to look at the table. No one wants to address the inequity of the tax system, which, some say, favors the rich. Our tax system, Congresswoman Pat Shroeder has observed, "allows a business woman to fully deduct a new Persian rug for her office, but not most of her costs for child care. It allows a greater deduction for a thoroughbred horse than for children."

Effects of the Erosion of Benefits

How has this benefits erosion process affected what candidate Bush declared to be of the utmost importance, what President Bush and our nation's governors committed themselves to — namely, the children and education? In both rural and urban sections of our country, increasing numbers of malnourished children are arriving at our school doors in conditions that can only be described as reminiscent of the Great Depression. Some of these children even now are suffering from the irreversible ill effects that come with the denial of early medical care.

I ask you, how can these children master the three "Rs" when their minds are focused on three meals? How can they grow up to be healthy, strong, productive Americans when their young bodies are ravaged by untreated diseases, such as measles and even polio, diseases we convinced ourselves had been defeated years ago? And how can education employees help them to overcome these hurdles when they themselves are engrossed in battles to maintain health benefits for themselves and their families? The painful answer is that they cannot.

Broadening Our Perspectives through the Forum

Our Association's policy in this regard is clear. We believe that a national health insurance plan —a plan that is mandatory, flexible, and provided by both public and private agencies — is the only way to ensure that all Americans have access to comprehensive health care. We also recognize that this issue demands and will receive more discussion, debate, and analysis before our nation seriously takes it to heart.

Some of the panelists you will hear at this forum will discuss that issue. Some will endorse it; some may oppose it. Some will discuss how various states and regions are handling the challenges stemming from retirement and benefits issues. However the issues are presented, I know the discussion will broaden our perspectives and deepen our understanding.

I know that the National Education Association and its two million members will benefit from your insights. We are in your hands. And I do not think we could ask for better care or caretakers. Once again, I thank you and wish you a productive and informative forum.

Three Critical Issues

Pensions and Benefits in the 1990s: Challenges and Opportunities for Pubiic Education Employees

Dallas Salisbury, Employee Benefit Research Institute

The shape of pensions and benefits in the 1990s will depend on how well we meet the challenges that currently face us. The Employee Benefit Research Institute conducted a survey that points out some of these challenges.

Challenges Revealed by Attitudes toward Social Security

Many survey respondents noted that they wanted to reduce Social Security taxes. When we asked these respondents whether they would still want to reduce the Social Security taxes if doing so would require income taxes to rise, over half changed their minds. And we all know that the deficit requires some taxes to rise if Social Security taxes are cut.

We then asked individuals another question in relation to the opportunity for employers and individuals to participate in alternative savings approaches. We asked, if you had the opportunity for part of the money you and your employer currently pay to Social Security to go into funding an employer-based pension or an Individual Retirement Account (IRA), would you prefer the system to remain as it is or would you prefer that type of reallocation to a prefunded retirement account? Over 60 percent said they would prefer the reallocation and a change in the system. We then asked our question in another way. We asked, do you favor the privatization of Social Security? Support then dropped to 35 percent.

What we learned from these questions and answers is that a very high sensitivity exists to the difference between maintaining the basic Social Security program and building a supplementary program, on the one hand, and trying to undermine the overall Social Security program, on the other. We need to make the line very clear if we are to move in the direction of change in the future.

Challenges Related to Dependent Care

Both employers and we as workers will face challenges in the 1990s regarding such secondary benefits as parental leave, elder care, and child care. These and other challenges have arisen as more two-income households and more women dominate the workplace. In fact, we are fast approaching the point at which more than half of the work force will be women, a dramatic change from even a decade ago.

Individuals understand the type of dynamic that produces these challenges. They were asked whether additional dollars, if included in employee benefits, should be made available to individuals to care for a family member, whether a child or an elderly parent. Over 81 percent of the American population say that this option should not be an opportunity; it should be a right. When asked only about child care, the numbers dropped

to 53 percent who felt that funding child care for individuals should be an absolute right. Nevertheless, 53 percent constitute a large number. When asked whether the government should provide a basis for helping individuals to finance child care through such avenues as the child care tax credit and flexible spending accounts, the support level rose to 76 percent. A challenge for all of us is translating that popular sentiment into local, state, and federal lawmakers' understanding that federal action is necessary to help us accommodate the changing work force of the future.

Challenges Related to Health Care and Benefits

As we all know, a topic that has been actively debated over the last several years is health care and health benefits. We all understand that dramatic increases in health care costs are a major challenge for all of us as individuals or as employers. Since many headlines imply tremendous dissatisfaction in America with health care, we asked how individuals feel about the health care they personally receive. We found that an overwhelming 84 percent are very satisfied or highly satisfied with the health care they personally receive within the system.

Nevertheless, systemic problems exist in the issues of access, of cost, and of quality. When we asked those individuals whether they are satisfied with the American health care system, those who are very satisfied or highly satisfied dropped to 32 percent. Clearly a need for change exists and implies a tremendous challenge and opportunity for education. This education of the general population, employees, co-workers, and others targets the strengths of the American health care system, on the one hand, and the cost of American health care, on the other. We need to be educated about being better consumers of health care, about the value of health promotion, about the necessity of wellness, the necessity of taking better care of ourselves. If you will, we need to be educated to emphasize in our day-to-day lives and in the day-to-day employment setting the importance of a morning's wellness walk and the importance of decreasing total health care spending by taking better care of ourselves.

Challenges Related to the Design and Funding of Retirement and Benefits Programs

Many challenges go beyond the basic issues of what individuals want and should be thinking about. In particular, we need to be concerned with how benefits are designed. We need to know how individuals should push, pull, coax, or cajole their employers. We need to make sure that we know why we have employee benefit programs, that we know what they are intended to achieve, and that we continue to design them in a way that meets those objectives.

All too often in the last decade both private and public employers, including the federal government, have modified programs to provide for lump-sum distributions rather than annuities, to provide for voluntary rather than mandatory participation. When the Employee Benefit Research Institute asked the Census Bureau in the field to see what people do with lump-sum distributions that they receive before actual retirement, we found that only 13 percent roll them over and save them for retirement, while 87 percent consume them. This finding leads to the argument that if the objective is retirement income, lump-sum distributions should not be legal. But Congress will have to be coaxed, cajoled, and persuaded to modify the law.

If we want to think about the question of annuities and defined benefit plans versus defined contribution plans in relation to objectives, we need only to focus on a simple statistic. When employers offer defined benefit plans, over 95 percent of full-time workers participate . On the other hand, an average of only 60 percent of employees choose to participate in defined contribution plans across the nation.

Who does not participate in defined contribution plans? The low income person does not. The person without personal savings does not. The person with the least ability to save does not. The person who will be the most dependent on Social Security does not. These are the people who most readily need the involvement of the union or the employer on their behalf to assure that they have money in retirement to allow them to pay the bills and, increasingly, to help them pay the higher costs of Medicare or employer-provided medical benefits.

We have challenges that we must meet. We need to seek aggressively to keep our employee benefit programs funded. We need to urge the Congress to make the funded surplus of Social Security real. We need to use our school districts and our state governments to assure that teacher retirement systems continue to be well funded. Regardless of what happens in a particular tax district, regardless of what happens to a particular bond issue, the money for tomorrow's retirement should already be set aside to accumulate investment earnings and to guarantee that we will be able to afford to retire. We need to begin urging employers to prefund retiree medical benefit liabilities. Finally, we need to have as an objective that the Congress is responsible enough about changing Medicare, in taxes as well as in benefits, to assure that Medicare survives for the long haul regardless

of whether it is as rich as it has been in the past.

Challenges Resulting from Changing Demographics

We all understand certain aspects of demographics. Not only are we all growing older, we all want to grow very old. And as we grow old, we know that we use more medical care. We know that health care spending will rise dramatically as the proportion of the population over the age of 65 moves from 12 to 25 percent per year, even though we also know that from 15 to 40 percent of the medical care that is provided is unnecessary. The average age of the American population is rising. The number of retirees is rising. The age of retirees is rising. Balancing benefit levels and costs during this time of tremendous change in the aging population will be a dramatic challenge.

Keeping this change in mind, we note that we spend $8 on an 85-year-old for every $1 we spend on a 30-year-old for medical protection. In the same context we spend $5 for every 65-year-old to $1 for a 25-year-old. These differences occur purely as a function of what one needs in medical care as a result of age. As the average age of the population increases, as the retiree population increases, and as the old-old population increases, controlling health care costs will become a greater and greater challenge for all of us. This challenge further involves enabling quality retiree health and health care. We need to assure that we balance who needs what and when. Finally, we need to assure that we do not overuse medical care to the point that when we need it most we cannot afford it.

Challenges Related to Long-Range Retirement Planning and Health Care

We have a challenge in the 1990s for people, employers, workers, the public, and Congress to focus on the necessities of retirement planning, long-range retirement planning. The educational challenge is huge. We must educate all individual workers and their dependents, all employers, and all lawmakers to understand the necessities of saving over a lifetime if we are going to afford the lifestyle that every one of us wants during retirement. People usually do not think that they will live as long as they actually do, and most do not do well at budgeting and disciplining themselves during retirement to have enough resources for the full length of their lives. This reality is part of the educational challenge. That challenge in the field of teaching is every bit as real as in every other field. You who are in the field of teaching are particularly able to find ways and opportunities to move forward on this issue.

The educational challenge extends to health education as well, in the 1990s and into the next century. Health education needs to reach other NEA members, students, communities, and the nation. It needs to focus on our being responsible consumers of health care, on the necessities of prevention, on the advantages of not smoking, on avoiding drinking to excess, on not doing things knowingly that make us more likely to develop dramatic health problems in our older years, and on guaranteeing that the nation spends more in the long term on health care. All of us share this educational challenge and opportunity.

Simultaneously, we have a challenge to step back and focus on a long-term view of what the total value will be of Medicare and Social Security. Considering public policy, we will almost certainly see increased taxation of Social Security benefits over time. By the end of the 1990s or early in the next century, some types of means testing will likely have to be introduced for Medicare. Without a doubt, payroll taxes both for Medicare and for Social Security will have to be increased. Certainly, as the annual budget expands to universal coverage, universal taxation will follow. Just as every American citizen will become a part of these programs, every American citizen will need to know what will or will not be present for the extended years of retirement.

Challenges for Protection of Plans

Yet another challenge that we have is the need to assess the value of and the opportunities for additional federal legislation to protect retirement and benefits plans. In such states as New York and California, years of surpluses have changed to a present of serious deficits. Tightened budget circumstances are forcing pressure on the funding of retirement income programs. The time may be nearing that federal regulations are needed to protect public retirement programs so that state, local, and school district politicians have no choice but to provide for full benefit security. Teachers and their organizations need to be concerned about this issue.

A final educational challenge exists for all of us working in the field of employee benefits. We need to make sure that lawmakers, employers, and others focus on defining goals and objectives for programs, on funding them, and on educating all participants about their programs. Participants need to understand the value of their retirement programs to themselves, to their parents, and to their children.

Our retirement programs form an economic security system for individual retirees that has grown more markedly than such programs in any other nation. Our retirement programs are being emulated by programs in Great Britain, Japan, and other nations. As their populations also age, they are looking to America in the need to build more supplements for individuals.

Meeting the Challenges

We clearly see a future in which individuals as workers must make sure that some individual retirement program is in place beyond a government program. The challenge of educating everyone about this need is pressing us in the 1990s. If we do not meet this challenge, shortly after the year 2000 we will begin paying the price of a dramatic change in demographics. The 1990s will be a period of flat, continued demographics in which our systems rely on past funding and continue to be sound. In the past we had to make changes and prepare for the realities of 1990. Now we must make other changes and prepare for the reality of the future.

Funding Issues for Public Retirement and Retiree Health Plans

Sophie M. Korczyk, Analytical Services

In their funding, private retirement plans must use one of a limited group of actuarial methods permitted under the Employee Retirement Income Security Act (ERISA). Public employee retirement systems (PERS) are not subject to a uniform funding standard, however. In the absence of comparable actuarial data, the ratio of plan assets to annual benefit payments can be used as a rough measure of funding status. It is widely believed that PERS should maintain assets equal to at least 10 times their current benefit payments to be considered at least minimally funded.

Plans in which coverage is limited to educators tend to be less well funded than general coverage plans. The Bureau of the Census collects data on state and local government employee retirement plans as part of the quinquennial Census of Governments. The Census of Governments does not provide actuarial data, but does provide plan-level data for calculating asset to benefit ratios. The most recent survey, published in 1989, covers the 1986-87 fiscal year. Out of 38 limited coverage plans for which data were available, 4 had ratios below 10 and 12 had ratios below 15 (Table 1). The average limited coverage plan had assets equal to just under 18 times its annual benefit payments in 1986-87. In contrast, among 39 general coverage plans including both educators and other state employees, only 1 had a ratio under 10, and 5 had ratios below 15 (Table 2). The average general coverage plan had assets equal to 24 times its annual benefit payments.

Emerging Issues in PERS Management

Since more than two-thirds of PERS income comes from investment earnings or employee contributions, educators should be concerned not just with plan funding, but also with how PERS assets are managed. The management of plan assets will determine benefit security, the cost of the plan to the employer, and the likelihood of ad hoc cost-of-living increases in plans without automatic increases.

Local Investments

The buildup of PERS assets over the last decade has coincided with increased budget austerity in many states and localities. Federal aid to state and local governments declined in both nominal and real terms, and state and local government tax and spending limitations became increasingly prevalent. As a result of these problems, some state and local governments have turned to PERS to supplement government resources. PERS have played two roles in state and local finance:

- Some states and localities have encouraged the investment of PERS assets to promote state or local job growth, economic development, or other goals.

Table 1. Asset to Benefit Ratios in Selected Limited Coverage Plans

Plan	Ratio of assets to benefits	Plan	Ratio of assets to benefits
Alabama Teachers	23	Ohio Teachers	17
Alaska Teachers	23	Ohio Public School Employees	10
Arkansas Teachers	25	Oklahoma Teachers	9
California Teachers	18	Pennsylvania Public School	14
Connecticut Teachers	16	Texas School Employees	20
Georgia Teachers	24	Vermont Teachers	19
Illinois Teachers	15	Washington Teachers	17
Indiana Teachers	8	West Virginia School Employees	3
Kentucky Teachers	16		
Louisiana Teachers	12	Chicago Teachers	20
Louisiana School Employees, nonteaching	25	Denver School Employees	18
Maryland Teachers (old)	11	Des Moines School District	24
Massachusetts Teachers	11	District of Columbia Teachers	7
Michigan School Employees	14	Duluth Teachers	17
Missouri Public School	37	Minneapolis Teachers	14
Montana Teachers	12	New York City Teachers	21
New Jersey Teachers	20	Omaha Public School	27
New Mexico Teachers	21	St. Paul Teachers	17
New York Teachers	27	St. Louis Teachers	23
North Dakota Teachers	22		

Source: Author's calculations based on *State and Local Government Employee Retirement Systems, 1987.*

Note: These plans have at least $20 million in assets.

Table 2. Asset to Benefit Ratios in Selected General Coverage Plans

Plan	Ratio of assets to benefits	Plan	Ratio of assets to benefits
Alaska Public	28	Nebraska Public	42
Arizona State	32	New Mexico Public	24
Arkansas Public	42	Nevada Public	25
California Public	21	New York Public	23
Colorado Public	28	North Carolina Public	23
Connecticut Public	10	North Dakota Public	50
Delaware Public	22	Oregon Public	29
Florida Public	23	Rhode Island Public	13
Georgia Public	22	South Carolina Public	33
Hawaii Public	16	South Dakota Public	36
Idaho Public	17	Tennessee Public	24
Illinois Municipal	21	Utah Public	35
Indiana Public	24	Vermont Public	18
Iowa Public	27	Washington Public	20
Kansas Public	22	West Virginia Public	23
Kentucky Public	26	Wisconsin Public	31
Maine Public	9	Wyoming Public	35
Maryland Public (old)	10		
Mississippi Public	23	Atlanta General	13
Montana Public	15	Baltimore City	19

Source: Author's calculations based on *State and Local Government Employee Retirement Systems, 1987.*

Note: These plans have at least $20 million in assets.

- Some states and localities have occasionally withheld or restructured pension contributions in response to budget difficulties.

PERS have come under pressure to invest assets in pursuit of various social, political, and economic goals. Some argue that PERS assets should be invested to aid local economies. Some recent examples:

- Ten states[1] agreed in 1989 to endorse a principle known as reciprocal or "Golden Rules" investing. These states agreed to invest PERS assets in each other's economies to promote growth and defend local companies against hostile takeovers.
- A California law enacted in 1988 authorizes the PERS Board to maintain up to the lesser of 1 percent of assets or $500 million in small business venture capital. The law also requires that the PERS report to the state legislature annually on the share of assets invested in California firms.

Advocates of local investing reason that a growing economy, fueled by PERS investments, will enhance the sponsoring government's ability to provide continued employment and benefits for plan participants. Such investments could reduce benefit security, however, if they result in a less diversified and riskier portfolio of assets.

Many PERS have also come under pressure to withhold investment funds from companies whose activities do not meet certain social goals. Experience with such restrictions differs across states.

A common restriction prohibits trustees from investing plan funds in stocks or bonds of firms with business ties to South Africa. The Maryland Court of Appeals recently upheld two Baltimore ordinances requiring city PERS to divest their holdings in companies doing business in South Africa even though divestiture imposed added costs and risks on the plan.[2] In contrast, the Arizona attorney general found that the State Retirement System's Investment Advisory Council was prohibited by state statutes from using strictly social or political criteria to guide investment strategy. The Council could, however, limit investments in companies doing business in South Africa if it found that such investments carried political risks and financial uncertainty for the plan.

Some funds may also direct trustees not to invest in firms with poor labor relations or to invest in firms or programs benefiting union members, such as mortgage loan programs that provide loans only for union members. New York Governor Mario Cuomo has urged state retirement systems to avoid investments in firms involved in leveraged buyouts.

Local and social investing pressures raise legal as well as economic issues for both plan trustees and participants. Legal issues for PERS may be particularly complex, as PERS may be subject not only to state and local law and legal precedents, but also to federal rules. Public plans are not subject to ERISA, which governs private retirement and other benefit plans. Nevertheless, according to Ian Lanoff, formerly the U.S. Department of Labor's pension administrator, "Courts that review activities of public plan trustees should be aware of the standards set for fiduciary behavior under ERISA and applicable case law" (Lanoff 1989).

What the law permits, moreover, may not always be in the best economic interests of plan participants and beneficiaries. ERISA requires that plan assets be managed for the sole benefit of participants and beneficiaries, but this standard governs intent more than results. Both ERISA and state statutes based on it prescribe procedural, not performance, standards for plan fiduciaries. In other words, a plan trustee is not required to be successful in managing the assets entrusted to his or her care, but only to manage these assets with prudence.

The Maryland case and others suggest that an investment decision that reduces plan returns below what the plan could otherwise earn may nevertheless be legally proper (Korczyk 1989). A decision that benefits a plan, in turn, may be improper if procedural safeguards were not followed. Consequently, participants should evaluate both local and social investing initiatives not only in political terms, but also in terms of their impact on the plan's security and participants' retirement income objectives.

Public employers have occasionally delayed, deferred, or canceled regularly scheduled contributions to PERS, usually to avoid incurring operating budget deficits. Some public employers have also reduced contributions formulas or withdrawn funds from plans to meet budget targets.

NEA Survey on Pension Plans of Public Education Employees

In connection with the present report, NEA undertook a brief survey of its affiliates to determine the

[1]Delaware, Idaho, Kentucky, Maine, Nebraska, New Mexico, North Dakota, Oklahoma, Pennsylvania, and Rhode Island.

[2]*Board of Trustees of the Employees Retirement System of the City of Baltimore v. Mayor and City Council of Baltimore City*, MD. Ct. App., Nos. 95 and 104, September 1, 1989.

prevalence of local and social investing and the timeliness of employer PERS contributions. The results of this survey are summarized in Table 3. The 49 states affiliates responding to the survey represented 79 state plans and 15 local plans covering educators.

The survey indicates that both issues are emerging as important policy questions in PERS covering educators. At least one in four states has used public employee retirement plan assets to meet non-retirement policy objectives.

Regularly scheduled employer contributions have been delayed, deferred, or canceled in 12 states. State and local budget difficulties appear to be accelerating in recent years. Seven states experienced these reductions since 1985. These events involved an estimated $540 million.

Employers are also reducing plan contributions through structural plan changes. Fifteen states reported that employer contribution formulas had been reduced in PERS covering educators since 1985. These reductions occurred for a number of reasons, including overfunding, government budget problems, and changes in funding approach, benefits, or interest rates.

Educators' plans in 17 states practice some form of social or local investing. The most common practice in this category was proscribing investment in companies doing business in South Africa. Economic development, housing, and venture capital investments were also cited.

The survey results only tell us wha. state and local governments are doing with their plans, not the impact these actions are having on the plans. More information is needed to determine which states are most likely to use retirement plan assets for non-retirement objectives and the effect such uses have on retirement benefit security.

Most NEA affiliates have a high opinion of the investment management of their plans. Asked to rank this performance on a scale of 1 to 5 with 5 being the best, 41 respondents gave their states a score of 4 or better, for an

Table 3. How Educators' Pension Funds Are Managed: Survey Results

Have regularly scheduled employer contributions every been delayed, deferred, or canceled?	Yes	12 states
Has this happened since 1985?	Yes	7 states
How much money was involved?		$540 million
Have employer contribution formulas been reduced since 1985?	Yes	15 states
Why? (Cite as many reasons as apply.)	9	Plan was overfunded.
	5	Government had budget problems.
	1	Benefits were changed.
	3	Funding approach was changed.
	3	Other reasons.
Do educators' plans practice local or social investing?	Yes	17 states [a]
How do you rank the investment management of your plan? (0 (worst) to 5 (best))		Average score — 4.2
		Average score — 4.2
		Most commonly cited reasons
		25 states: return
		9 states: management

Source: NEA Survey on Pension Plans of Public Education Employees. For responses by state, see Appendix.

Note: Responses are based on 79 state-administered plans and 15 locally administered plans in 49 states. Detail may not add to total as not all respondents answered all questions.

[a]Total based on state responses as well as other information gathered for this report.

overall average of 4.2. The most frequently reported reason for a high ranking was the rate of return achieved by the plan or plans, but return was cited as a reason for several low scores as well. Many respondents were pleased by frequent evaluation and close monitoring of investment performance.

The NEA survey and Census data both suggest that most educators' plans are well managed, offering adequate security in terms of both funding and the techniques used to monitor investment performance. Two caveats must be offered to this statement. First, plans covering only educators tend to be less well funded than general coverage plans. Second, a significant minority of both types of plans are operating on a pay-as-you-go basis. These plans have little or no margin for adverse investment experience or local economic conditions that could prompt a surge in retirements.

In a national or local recession, poorly funded plans could find it difficult to meet their benefit commitments and could require general revenue subsidies from their sponsoring employers. Thus, there is reason for concern about both funding and management in some educators' retirement plans.

Funding Issues in Retiree Health Plans

It is well known that retirees use more health care than other age groups. As employees retire earlier, live longer, and demand access to high-technology medical procedures, retiree health care is becoming increasingly expensive to provide. Furthermore, health care costs are continuing to rise faster than overall inflation, making many employers concerned over their long-term ability to meet their retiree health commitments.

Benefits are unfunded.

Most private and public plans have no funds accumulated to pay future benefits. The Employee Benefit Research Institute (EBRI) has estimated that unfunded liabilities in federal, state, and local plans totaled approximately $111 billion in 1988. If liability is proportional to the number of employees covered, the state and local share of this total would be about $95 billion.

Retiree health liabilities could add significantly to unfunded PERS liabilities. NEA data suggest that the typical PERS is 69 percent funded. Based on this estimate, unfunded pension liabilities of state and local governments could total as much as $230 billion. The EBRI estimate of retiree health obligations would add another 40 percent to this total.

Employers are terminating plans.

Neither case law nor statutory law clearly defines employee rights under retiree health plans. Consequently, some employers have attempted to terminate or modify retiree benefits to contain their costs. Most litigation has involved the plans of private employers, though at least one public sector dispute has reached the courts. The city of Chicago attempted to terminate health benefits for retirees and their dependents in 1988, but reached an agreement with the annuitants and the pension funds to continue benefits for another 10 years. The city, the funds, and the annuitants will pay increased costs as part of the agreement.

Thus, predicting how the courts would treat plan terminations by public employers is difficult. However, cases involving private employers, particularly in collective bargaining settings, are useful in elaborating some of the legal principles at issue. Some companies have attempted to terminate retiree welfare benefits after the end of the collective bargaining agreement under which the benefits were provided. In deciding whether to permit plan termination, the courts have first looked to the language of the contract regarding postretirement benefits (Sacher and Miller 1988).

If the contract language does not clearly define the rights of the employer and the participants, courts have looked to past agreements, verbal statements and plan documents provided by the employer, and the employer's conduct. For example, an employer that continues to provide retiree benefits during a strike could be demonstrating an intent to continue providing these benefits to employees for life, even if the contract specifies, or can be construed to specify, otherwise.

The courts have also found that the nature of retiree benefits creates an implicit inference that the parties to the contract intended the benefits to continue beyond the contract's term. Once retired, an employee can no longer negotiate for improved benefits or seek other employment where these benefits may be provided. According to one authority, even a clear statement in a labor contract or plan documents that explicitly limits the duration of retiree medical benefits now may be unenforceable (Sacher and Miller 1988).

Benefits promised to active employees are changing.

Active employees should note that court cases have limited only the ability of employers to terminate benefits for employees already retired. The biggest bulge in retiree health costs is still to come when the baby boom — now age 26 to 44 — retires. Nothing prevents

employers from limiting the future benefits promised to active employees. For example, York County, Pennsylvania, has discontinued retiree health coverage for employees hired after January 1, 1989. Employers who continue to maintain their plans are likely to increase the retiree's share of premium costs.

Rather than terminate coverage, some employers are beginning to experiment with alternative benefit designs. The traditional plan in which the employer provides an open-ended benefit is giving way to plan design options that limit the employer's costs.

One design option being adopted by some private employers is the defined contribution retiree health plan. This option makes the employer's liability more predictable. The employer promises to make a given contribution to the retiree's coverage, whether or not this contribution covers all or even a constant share of these costs. Limiting the employer's liability makes it easier to predict and fund for it. To maintain coverage, however, retirees may have to bear large and unpredictable premium increases.

Public employers have also moved further than private employers in imposing eligibility and vesting standards for retiree health benefits like those imposed in retirement plans. In most private plans, employees are vested in the retiree health plan upon retirement from the employer, but some public plans link employer contributions to length of service. While such restrictions can limit the level of employer costs, they do not make these costs more predictable or limit their rate of increase.

New reporting requirements will prompt further changes.

Employers' efforts to restructure retiree health benefit plans could be accelerated by proposed new disclosure standards for retiree health benefits offered by public employers. On November 3, 1989, the Government Accounting Standards Board (GASB) issued a proposed statement, or exposure draft, on public employer accounting for retiree benefits other than pensions.

The proposed standard would require government employers to disclose the benefits offered; the employee groups covered; employee and employer obligations to contribute; the statutory, contractual, or other authority under which the benefits are established; and the accounting and funding policies used. Employers would also be required to disclose the expenditures and expenses for these benefits recognized for the period and related data.

The statement has been released for comments at this stage and could be modified before it becomes effective. Faced with expanded disclosure requirements, employers with large unfunded liabilities could decide to limit benefits rather than spend more or find their credit ratings impaired.

What Educators Can Do

Educators can take a number of steps to ensure their benefit security in the face of fiscal pressures at all government levels. State and local governments issue financial statements that disclose their employee benefit liabilities and the provision they have made for these obligations. ERISA requires private plan sponsors — but not public employers — to provide their employees with a summary annual report containing the financial information a plan sponsor must disclose to the Internal Revenue Service each year. If a state does not require similar disclosure, educators need to lobby for such information to be made available.

NEA affiliates also need to evaluate the adequacy of their participants' retiree health care coverage and take steps to minimize the number of retirees who fall through the cracks of the intersecting federal, state, and local retirement income systems. Where coverage gaps exist, the sponsoring government needs to plan for them in the present and set aside reserves to provide needed benefits.

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Appendix. Detailed Results of NEA Survey on Pension Plans of Public Education Employees, 1990

Regularly scheduled employer contributions have been deferred, delayed, or canceled:

Alaska	Illinois	Louisiana	Pennsylvania
Arizona	Indiana	Michigan	Texas
California	Kentucky	New Hampshire	West Virginia

This has happened since 1985:

Alaska	California	Kentucky	West Virginia
Arizona	Illinois	Pennsylvania	

Employer contribution formulas have been reduced since 1985:

Alaska	Connecticut	New York	Texas
Arizona	Delaware	Oregon	Utah
Arkansas	Kansas	Pennsylvania	West Virginia
Colorado	New Jersey	Rhode Island	

Educators' plans practice local or social investing:

Arizona	Florida	Nebraska	Oklahoma
Arkansas	Idaho	New Mexico	Oregon
California	Kentucky	New York	Pennsylvania
Connecticut	Maine	North Dakota	Rhode Island
Delaware			

The New Medicare Physician Reimbursement Schedule

L. Maynard Oss, Biotrak Service Corporation

In 1954 I signed a multipurpose contract to be a high school principal, to teach chemistry and biology, and to coach three sports — all for a salary of $3,600 for the year. In the spring of that school year my wife had our first child. The doctor bill was $52, and the hospital bill was $75, the total representing 3 percent, or 1/33, of my salary. Last year the average teacher in Minnesota, my home state, was paid $37,500. On the other hand, the average charge for normal delivery, including both hospital and doctor bills, was nearly $5,000. This amount represented 13 percent, or 1/7, of the salary, a dramatic increase from 1954.

What has happened? Costs for medical services have grown so rapidly that the federal government has tried all kinds of measures to control them. In this context the Resource-Based Relative Value Scale (RBRVS) has been developed as a new fee-for-service system, which will be applied to Medicare physician payments beginning in 1992. Note that RBRVS is a fee-for-service system, not a bundled system such as diagnosis-related groups and not a capitation system such as health maintenance organizations. The development of the relative value scales for the payment of physician services, however, is not a new approach.

The Failure of Charge-Based Relative Scales and Strategies Using Them

The development of a relative value scale dates back to the early 1950s. The prototype was published by the California Medical Association in 1956 as the California Relative Value Scale. Subsequent editions with revisions were published in 1957, 1960, 1964, 1969, and 1974. The California scale used current physician fees as its base. On the other hand, RBRVS uses resources as its base. Despite its wide use, the California scale does not compare well with RBRVS. For the most part, nearly all fee schedules and relative value scales developed up to the present have been charge-based. They simply institutionalize whatever price distortions already exist in an imperfect marketplace. For this reason, if a payment system is to be equitable and rational, it must be independent of existing charges.

Why did the government need a new fee schedule? From 1969 through 1976, Medicare payments were out of control. To control costs, Medicare reduced payments from the 90th percentile to the 85th percentile and later to the 70th percentile of usual and customary charges. Despite these reductions, physician payments continued to soar. Most of the increase in payments to physicians has occurred since 1973. Responding to these increases and trying to control costs, Medicare devised a system reverting to 1972 fees and applying a Medicare Economic Index. This system became known as Customary, Prevailing, and Reasonable (CPR) Charges. It was Medicare's variance from the usual customary and reasonable charges. The CPR method compiled the actual charges made by physicians in a base period of

1972. The 1972 prevailing charges were adjusted to the Medicare Economic Index. The Index is based on a number of national economic factors relating to physicians' overhead costs and net income. It was first implemented in fiscal year 1976 and was based on 1973 prevailing charges.

Following this development, from 1976 through 1983 physicians were paid on an adjusted CPR. The results were just as disastrous as they had previously been. Medicare payments soared much faster than either the GNP growth rate or the inflation index. Since Congress was basically out of money in 1984, it froze both customary and prevailing charges. With the exception of some minor adjustments, Medicare's physician reimbursement has been based on 1983 CPR. How long can we call a 1983-based fee CPR? It's not customary, it's not prevailing, and one wonders if it's reasonable.

The CPR method of reimbursement has created a number of problems that can be grouped into four general categories. First, CPR tends to promote fee inflation. The physician whose fees are below the prevailing charges has an incentive to increase his or her customary fees to the maximum allowable level. Second, CPR promotes inequities between new and experienced physicians. New physicians often charge more than experienced physicians. Many inequities exist. Third, CPR fosters a disparity of fees. The current CPR method encourages physicians to continue charging their old fees regardless of changes in technology, risk, and time input. Thus, further distortions occur between what is charged and what should be charged. Finally, CPR tends to compensate physicians for diagnostic and surgical procedures at a higher rate per unit of standardized time than for office visits or consultations involving history taking, counseling, or other cognitive services. The higher payment levels may be due to the fact that surgical services and diagnostic tests have been covered by health insurance for more years than office visits. As we are aware, the longer something is covered by health insurance, the more unreasonable its costs become.

The Development of RBRVS

In 1985 physicians' complaints about the freezing of 1983 fees became an effective lobby. Through the Omnibus Reconciliation Act of 1985, Congress instructed the Health Care Financing Administation to devise a fair and equitable payment schedule.

Harvard Medical School, under the direction of Dr. William Schao, was charged with this task and masterminded what is now known as the Resource-Based Relative Value Scale (RBRVS), a new method to establish relative values without using any current reference to physicians' charges. In brief, the resulting RBRVS reflects the relative values of medical and surgical services based on the resource costs involved. The model computes the relative values of physicians' services as if they were in a competitive environment. It was constructed to be neutral in relation to the selection of diagnostic or therapeutic modalities. In other words, the payment system was intended to create a level playing field.

Exploratory Studies

At the beginning of the research that would lead to the RBRVS, the Harvard group knew that only a resource-based schedule would eliminate the unfairness and the distortions of the past. They originally considered a combination of five resource inputs:

- operative, or encounter, time (also known as skin-to-skin time)
- pre- and postoperative encounter time
- the complexity per unit of time
- overhead costs
- the amortized value of opportunity lost in the specialty training after medical school

The first exploratory study analyzed the relative resource inputs of 27 procedures commonly performed by physicians in five specialties — general surgery, orthopedics, gynecology, ophthalmology, orthopedic surgery with urology. The approach to quantifying work was to measure the duration and complexity per unit of time in each service. Examination of the data revealed a high degree of correlation between the duration of a procedure and a physician's estimate of its complexity per unit of time.

A second study of resource-based relative values was conducted on data from 110 physicians in Massachusetts. It added four nonsurgical specialties (internal medicine, pediatrics, family practice, and radiology) and two surgical specialties (otolaryngology and thoracic and cardiovascular surgery) to the five specialties in the previous study. In both studies the physicians' estimates were strikingly consistent, particularly with respect to the rank ordering of procedures.

Two other major findings can be summarized. First, the authors found large discrepancies between charge-based and resource-based relative values when they evaluated what should be paid. This finding suggests that office visits for evaluation and management of patients are undervalued in relation to invasive procedures.

Estimates indicate that charges and payments for invasive procedures are, on the average, two to three times higher than those for medical evaluation and management. In addition, the study revealed that technical diagnostic procedures, such as laparoscopy, kinescope, and rigid sigmoidoscopy, are also paid at two to three times what they should be paid when compared with office services.

Second, the study found that the most commonly performed surgical procedures of moderate difficulty are better compensated in relation to resource inputs than the most complicated and less frequently performed procedures. The current system offers no incentive or market pressure for physicians to lower prices when technology and efficiency have improved.

Developing Primary Data for Defining and Measuring Work

A major task of the Harvard group was to define and measure work both quantitatively and qualitatively. Instead of accepting that work consists of two independent factors, time and intensity, the Harvard group determined through extensive face-to-face qualitative interviews the dimensions that practicing physicians considered to constitute work. The interviewed physicians typically described the most important variables in their work as follows:

- time
- mental effort
- knowledge
- technical skill
- pre- and postservice effort
- psychological stress

Further discussion and review by the panelists tended to confirm these dimensions. When asked what determined the level of work input for individual patients, the interviewed physicians commonly cited the complexity of a patient's problem, the seriousness of a patient's condition, uncertainty about the diagnosis and treatment, and the possible unintended harm to the patient.

The Harvard group was careful to consider all these six variables in relation to the three phases of work —preservice, service, and postservice. These combined factors explain virtually all the variances of total work and provide the basis for a total work formula, or the RBRVS formula. For the development of the formula, ratings that summarized the total work involved for services on a magnitudinal scale were obtained for all separate dimensions of work.

The RBRVS was then developed in the following way. Approximately 20-25 physicians in each specialty and each subspecialty rated the total work for only the procedures they customarily performed without comment or influence of the other groups of physicians. Then respondents were asked to use their own scales to rate items in relation to a reference item without imposing a fixed upper or lower limit. The reference item was selected as a standard for measurement of other activity. Each specialty was provided a different reference item with a value of 100. For example, in general surgery, the standard of 100 was uncomplicated indirect hernia repair in a 45-year-old male. Respondents were allowed to rate an item as high or as low as they believed necessary to reflect reality in relation to the standard. Further, these physicians were asked to provide their magnitudinal ratings separately on each of the 6 components of work in the three phases — before, during, and after the clinical encounter for an invasive procedure — for a total of 18 components. If physicians judged a service to be twice as much work as the standard, they would give that service a value of 200. A service with half as much work as the standard would be rated at 50. A service with five time as much work as the standard would be rated at 500. The data collected in this phase of the research served as the primary data in developing RBRVS.

Verification of Ratings

The ratings of these 20-25 specialists in each area were next examined by 120 randomly selected members of the same specialty. With very minor exceptions, all 18 specialty groups of the random panels agreed with the relative value scales established by their specialty, which was prepared by 25 physicians in their specialty. Next, all schedules were submitted to the appropriate specialty society. For example, the schedule for pediatric services was submitted to the American Academy of Pediatrics, and so on. The Harvard study demonstrated a confidence level of 99.4 to 99.8 of the total work assigned each procedure. This confirmation resulted in 18 separate, resource-based, relative value schedules (RBRVS).

Collapsing 18 Schedules into 1

Following this level of verification, the next task was to collapse all 18 of these schedules into 1 schedule, which was developed by the use of common links between and among specialties. For example, treating urinary tract infections is done by general practitioners,

internists, and urologists. The scales for each specialty were examined and combined into one. Next, comparisons of commonality were drawn on different procedures, regardless of specialties, that had equivalent ratings. For example, a comparison of commonality revealed that a radiologist's work in conducting a barium enema is equivalent to a pathologist's performing an examination of a lymph node. The resulting realization was that two separate schedules could be merged without affecting the integrity of either specialty. These different kinds of comparisons led to merging procedures from all 18 specialties into 1 RBRVS schedule.

Findings

The preliminary study that developed the single RBRVS schedule provided four statements of findings:

- Physicians can agree on relative value scales.
- Large discrepancies exist between what should be charged and what is currently charged.
- Unlike the case in industry, medical and technological improvements do not reduce costs or result in lower prices.
- No incentives exist for physicians to lower prices.

Some adjustments had to be made for different intra-service time, such as the 26 percent more time that the primary care internist spends over an obstetrician-gynecologist (ob-gyn) in a particular case. Such difficulties have been resolved with a minimum of problems.

Using RBRVS Values to Establish Fees

The final RBRVS does not assign a dollar value for any particular service. The final RBRVS values are based on what the government would have paid for all medical services in 1986 if it redistributed the same amount of money according to this RBRVS value. A fictional example will illustrate how the RBRVS values can be used to establish fees. When all the comparisons were made and the 18 schedules were merged into one, the RBRVS revealed that a surgeon's fee for a tonsillectomy would be eight times the fee for an office call with a general practitioner.

Prior to RBRVS, however, a general practitioner had to submit bills for 37 office calls to collect as much money as the surgeon collected for one tonsillectomy. If the general practitioner received $1 for each of the 37 office calls and the surgeon received $37 for the tonsillectomy, the total is $74.

RBRVS would redistribute the same $74 in a different manner. Because a surgeon can only receive a fee equal to eight times the fee for an office call, he would receive only $13 and some cents instead of $37, and the general practitioner would receive approximately $1.60 for each of the 37 calls. As you might imagine, the American College of Surgeons is now the only organized medical group that has withdrawn its support for the RBRVS system. Nevertheless, all the surgeons and all the family practitioners still agree that a surgeon performing a tonsillectomy is entitled to a fee eight times greater than that for a general practitioner's office call. Both groups state that the relative values of RBRVS are correct.

Look at the same situation from another perspective. Medicare currently pays general practitioners $33 for an office call. Given that fee, a surgeon is entitled to $264 for a tonsillectomy. If Medicare raises the price of an office call to $50, the fee for a tonsillectomy would be $400. However, in order for surgeons to get their current $800 for a tonsillectomy, Medicare would have to pay a general practitioner $100 for an office call. In this regard remember that RBRVS does not assign a dollar value to any procedure, but it does say that payment should be according to value and not according to historical pattern.

This battle between the specialties is not the only problem. Some major arguments are going on within the specialties. Within specialties changes are required by RBRVS. According to RBRVS the fee for office calls of ob-gyns needs to be increased 300 percent. However, the fees for most ob-gyn surgical procedures need to be reduced 37 percent. Given this discrepancy, we should not be surprised that we have a problem in the United States with excessive hysterectomies when we pay an ob-gyn a 37 percent bonus for performing the surgery. Even with such a discrepancy, the professional associations of ob-gyns endorse the new RBRVS schedule.

Considerations Unique to RBRVS

RBRVS involves considerations that other fee schedules never addressed. First, RBRVS takes into consideration the difference in malpractice insurance fees for different specialties, for example, ob-gyns and general surgeons. Next, RBRVS takes into consideration that psychiatrists have only 67 percent of the office costs of a general surgeon, while the rheumatologist has 14 percent more office costs than a general surgeon. Consequently if these specialists did equivalent work, RBRVS would entitle them to payment as follows: $67 for the psychiatrist, $100 for the surgeon, and $114 for the rheumatologist. Yet another factor is called loss of

opportunity. It concerns such specialties as allergists, rheumatologists, and thoracic and cardiovascular surgeons. These specialties require years of additional training, the costs of which cannot be recovered without the payment of a bonus.

RBRVS did not introduce differences in physicians' fees based on geographic location. Every fee schedule that is commercially sold and every fee schedule that Medicare has used has had such an adjustment. Anyone who has had anything to do with paying claims knows that the geographic distortions of physicians' fees are excessive. For example, the fee for normal delivery is approximately $1,200 in upstate New York, but is nearly $5,000 in Manhattan. Undoubtedly, the cost of living in Manhattan is higher than in upstate New York, but not that much higher. Biotrak, the company for which I work, is based in the twin cities of Minneapolis and St. Paul. The difference in fees charged in these two adjacent cities where no cost-of-living differentials exist is staggering. RBRVS also acknowledges geographic differences in cost of living, which can be adjusted on a monthly, quarterly, semiannual, or annual basis, but it does not recognize such historical differences in fees as those in New York and in the Minneapolis-St. Paul area. Thus we have another reason to appreciate RBRVS.

Dealing with Abuses

We have now covered all the input needed to arrive at the RBRVS fees. We have covered pre-, intra-, and post-service activities. We have covered time, mental effort, knowledge, technical skill, physical effort, and psychological stress. We have covered the differences between practice costs and the difference between amortization and lost opportunity. Next we need to look at abuses and how to deal with them.

The abuses going on in medicine today are severe. After many years of experience, in April 1990 the American Medical Association admitted that in 1989 up to 30 percent of all the procedures, up to 30 percent of all the hospital days, and up to 50 percent of all the medication that was used were medically unnecessary. As a businessman I am deeply concerned to think that our nation is even considering nationalized medicine when nobody has proposed a method to control the impropriety both of patients and of doctors.

Additional points need to be noted. The prices of some physicians' surgeries are being reduced. For example, cataract surgery of the eyes has been reduced from $4,200 to $900. Senator Lloyd Bentsen, on the other hand, led the fight in the implementation of RBRVS to restrict cuts of any physician's income to no more than 15 percent. Congress, through the Bush Administration and the Health Care Financing Administration, is implementing RBRVS with this 15 percent limitation in mind. Certain procedures are being phased down until they come in line. For example, radiological payments are being reduced by 4 percent per year until they reach the required level, Surgery fees are being reduced, but not in sufficient amounts to increase the proportion of office visit costs, since so many office visits are required to equal the effect of the reduction in surgery fees. Primary care physicians' fees, therefore, will go up only 4.2 percent as the overpaid surgical fees are adjusted down by 15 percent. On the other hand, nuclear physicians, who have been severely overpriced, have created a whole new set of codes rather than incorporating changes in the codes they previously used. As a result, Medicare has blended costs back into radiological schedules if treatment involves radioactivity, has capped payment on approximately 270 procedures, and has reduced claims and adjudication costs in a series of controls that have been instituted.

Another point concerns false reporting. The number one problem for private claim payers is what is called "code creep." Basic office visits, 1-5 minutes, should be 50 percent of the physician's calls; intermediate office visits should comprise 45 percent of the calls; and comprehensive office visits should be 5 percent of the total. In 1988 in Georgia, internists billed Medicare with 75 percent of their office visits as greater than basic. One physician who was investigated would have had to work 300 hours a week to compensate for his billing. RBRVS will help both Medicare and the private sector to stop the abuses.

In implementing RBRVS, the government also has provided only a 9 percent increase in Medicare payments and has established the control of maximum volume performance standards. This control means that if a physician performed 100 tonsillectomies last year, this year that number and the amount paid for them could increase by only 9 percent. This control also restricts the overcharges of surgeons who misrepresent the surgeries they have performed, including coding double bypass surgery as quadruple bybass surgery. Remember that the increase in fees is limited to 9 percent for 1990.

We further need to recognize that the federal government is seeking to regulate payment, not fees that physicians charge. We will most likely not see a federal law regulating physicians' fees according to a schedule. The government's only recourse against excessive fees is limitation of payment. The patient may sign a statement verifying that the doctor has stated the fees to be over and above the usual charge for whatever reason, but that

statement does not mean that the physician will be paid that amount by Medicare or by the insurance company.

Response of the Medical Community and a Challenge

What is the consensus of the medical community in relation to RBRVS? The total medical community has accepted the relative values of RBRVS. Some specialties believe that they need to adjust some of the differences between relative practice costs. Some, especially the surgeons who feel they are not overpaid but are paid adequately, may see their fees decline.

Nevertheless, when the RBRVS study was released in the fall of 1989, James Todd, M.D., then president of the American Medical Association, evaluated RBRVS as being put together honestly, as an excellent fee schedule, and as superior to the other fee schedules. He also said that although RBRVS deserves the support of medicine, it will not correct all of the abuses.

Despite controls, no one should expect RBRVS alone to control or to reduce health care expenditures. RBRVS will simply rationalize payments to physicians. At the same time the AMA recognizes that RBRVS will require a continuing focus on volume and intensity of services by physicians. Efforts to increase the appropriateness and effectiveness of medical care and to restrain inappropriate patient demand will make the million-dollar RBRVS project pale by comparison. How wholesale is the abuse of physicians' fees? Approximately 20 percent of all U.S. physicians are really aggressive in their billings, and "really aggressive" is a polite term. The government has allowed so much misbilling to go on that total disaster will occur if the government institutes major changes in our health care system before correcting these abuses. The disaster will be similar to that being experienced by countries with nationalized medicine. These countries, including Sweden, finally forced the retirees to take the brunt of paying for socialized medicine.

From our perspective at Biotrak, we have a challenge and an opportunity with the Resource-Based Relative Value Schedule. If we learn to use it propitiously, we have the possibility of avoiding the excesses and the problems of the countries that have instituted nationalized medicine.

State Health Plans
The Hawaii Plan

Marilyn Matsunaga, Hawaii State Department of Health

A brief historical overview of health care development in Hawaii is helpful for an understanding of what Hawaii has achieved in health care.

In the late 1800s sugar and pineapple companies were major employers in the islands. These companies were developed from large land tracts granted to missionary families by the Hawaiian monarchy. Hundreds of agricultural acres were cultivated from these land holdings. Immigrant groups largely from China, Japan, Portugal, and the Philippines were brought to the islands to work for the companies. The companies portrayed themselves as paternalistic figures to their employees and provided them with austere housing, stores, and health clinics in established "plantation" communities.

The Hawaiian monarchy established a department of health in 1850. This predates the establishment of all departments of health in the United States by about 10 years. Early on, Hawaii's government system recognized the importance of having a health agenda and was on its way to becoming the nation's "Health State."

In 1945 the International Longshoremen's and Warehousemen's Union (ILWU) instituted an industry-wide provision of health care benefits in the collective bargaining process. Health benefits were provided for a small fee to employees and their dependents for inpatient and outpatient care at the company hospital by the company physician. It was a closed prepayment health care system. Later, in 1954, the ILWU supported legislation for the establishment of prepaid group plans, which opened the gateway for health maintenance organizations, such as Kaiser-Permanente, to come to Hawaii.

In 1960 the Longshoremen contributed $10,000, a rather large sum in those days, to the founding of the Hawaii Dental Service. The money was used for a children's dental plan, which has now grown to include dental care coverage for employees and their spouses.

Health care service utilization by Hawaii's citizens was positively affected by union activity in the state. Union accomplishments made health care more accessible and thus introduced new health care usage patterns into the community. At least partially as a result, Hawaii citizens now have the greatest life expectancy of any state; the lowest rate of heart attacks and heart disease; the lowest incidence of cancer, chronic lung disease, and emphysema. As well, the state's per capita hospitalization rate and hospital average-length-of-stay rate are among the lowest in the United States.

Hawaii's Three-Part Health Plan

Hawaii has been and continues to be a leader in providing access to health insurance and, thereby, health care. The new Hawaii State Health Insurance Plan (SHIP) was developed to work in partnership with two existing programs, Hawaii's Prepaid Health Care Act and Medicaid.

The Prepaid Health Care Act

Passed in 1974 by the Hawaii State Legislature, the Prepaid Health Care Act made the provision of health insurance and medical protection for Hawaii's employees mandatory. It was designed to protect employees from excessive health care cost burdens. Concurrently in 1974 Congress adopted the Employment Retirement Income Security Act (ERISA) to improve protection afforded to employees participating in employee pension, health, and welfare plans. ERISA preempted any state laws that could potentially come into conflict with its provisions. However, as a result of Congressional and legal actions, Hawaii gained exemption from ERISA. It is the only state to be exempt from the federal act.

Hawaii's Prepaid Health Care Act, administered by the Hawaii State Department of Labor and Industrial Relations, was instituted to offer a certain measure of protection against a medical emergency's consuming all or an excessive part of a person's resources. Among its basic principles are the following:

- Every regular employee in private employment shall be protected by a prepaid plan providing for hospital, surgical, and medical benefits.
- Unless a collective bargaining agreement or a self-initiated employer's policy provides for an allocation of costs more beneficial to the employee, the costs shall be shared by the employer and the employee.
- The scheme does not intend to interfere with the collective bargaining process or interfere with the services provided pursuant to such collective bargaining agreements.

The Prepaid Health Care Act is the only state-mandated benefits program in the nation. It is a plan in which health care costs are shared by the employee. The employer pays 55-60 percent of the monthly premium, and the employee pays 40-45 percent. In Hawaii monthly premiums average about $85-$100 for an individual and $185-$200 for a family.

In order to be eligible for prepaid health care, a regular employee must work for one employer for at least 20 hours per week or earn 86.67 times the minimum wage per month. Minimum wage is presently about $3.85 per hour. Approximately 88 percent of the population fits into this profile.

Persons excluded from the Prepaid Health Care Act include government workers, since they have their own plan; seasonal agricultural workers, such as those who help harvest coffee; salespersons who work strictly on a commission basis; small family businesses, such as mom-and-pop stores that employ only family members; government assisted program recipients; and in some cases employee dependents, since dependent coverage is an option that some programs do not offer.

The Prepaid Health Care Act provides for comprehensive health care coverage in the following care categories: hospital, medical, ancillary, maternity, and surgical. For example, hospital benefits range from inpatient care to nursing care, drugs, and blood services. Medical benefits include home visits and medical consultations. Ancillary services covered include laboratory and x-ray needs. Maternity care is covered for those who have been employed at the company for the previous nine consecutive months. Surgical services are also covered.

Medicaid

Medicaid is the second existing program that the new State Health Insurance Program supplements. Hawaii has one of the most liberal and comprehensive Medicaid systems in the United States. An estimated 67,000 persons, or approximately 7 percent of Hawaii's population, participate in this program statewide. Its annual budget for fiscal year 1990 is approximately $200 million. Medicaid is administered by the Department of Human Services.

To qualify for Medicaid benefits, one must be a resident of Hawaii and have an income level below 62.5 percent of the federal poverty level, which is approximately $602 per month for an individual. For the elderly that rate is set at 100 percent, and for teenage mothers it is set at 185 percent. In addition, an individual must meet certain asset limitations.

Hawaii has a comprehensive array of services covered by Medicaid. The Medicaid population in Hawaii is eligible for inpatient and outpatient care, long-term care, ancillary care, and physician services as well as 13 other categories that range from podiatry to family planning.

Hawaii's Gap Group Profile — a Need to Be Met

A gap group of uninsured persons exists in Hawaii even with the success of Hawaii's Prepaid Health Care Act and Medicaid. This group is presently estimated to represent about 5 percent of the state's population, or 50,000 persons. This figure was derived from studies done 1977, 1978, and 1979 by the Hawaii State Department of Health. In addition, the department conducted a survey of Hawaii's public school student

population and found that about 5 percent of that population comes from families who do not have health care coverage.

Hawaii's gap group of 5 percent is in sharp contrast to national data. In 1983 the Robert Wood Johnson Foundation, the nation's largest health care philanthropy, estimated that some 35 million Americans lacked health insurance. U.S. Census data put the health care gap group at 17.4 percent of the nation's population.

The implementation of the Prepaid Health Care Act dramatically reduced the size of the gap group. In 1971 the initial studies for the Prepaid Health Care Act found that the uninsured in Hawaii represented between 11.7 and 17 percent of the population. After the act was implemented, the gap group decreased tremendously, to a level of 1.8 to 3.9 percent of the state's population. More recently the size of the gap group has increased to about 5 percent. This difference is mainly attributable to demographic shifts and trends, such as those related to an increased immigrant population. At 5 percent, Hawaii's rate of uninsured is the lowest in the nation.

Study estimates indicate that the gap group is composed primarily of the following persons: the unemployed; dependents of low-income workers, primarily women and children; part-time workers, those who work under 20 hours per week; those living in rural areas of the Neighbor Islands, that is, all islands but Oahu; immigrants, particularly those from Asian and Pacific nations; seasonal workers; and students. Note that these groups correlate highly with those excluded from the Prepaid Health Care Act.

Hawaii's New State Health Insurance Program (SHIP)

In order to have universal access to health care in Hawaii, a third program was needed. Thus the State Health Insurance Program, or SHIP as it is commonly called, was created. SHIP provides access to basic health care services for all of Hawaii's people by building upon Hawaii's Prepaid Health Care Act and Medicaid. It ensures basic health coverage for all Hawaii residents.

With SHIP, Hawaii is moving away from a traditional model of care, which concentrates on treating illness, and toward a more contemporary model, which actively promotes prevention and wellness. In keeping with its contemporary focus, SHIP's purpose is to guarantee access to necessary health care and thereby to promote wellness as a means to reduce future health care costs. So often the uninsured wait too long before they go to a physician and gain access to the health care system. By that time they often need care that is costly and that may approach catastrophic care. SHIP encourages the use of preventive health care services, which are less costly in terms of personal trauma as well as dollars.

SHIP is a basic program with the following objectives:

- to encourage the use of preventive health care services
- to improve the utilization of services offered via the Prepaid Health Care Act and Medicaid by discouraging program shifting and by strengthening SHIP's links with Medicaid
- to reduce the number of medically indigent in Hawaii by approximately 80 percent
- to reduce hospital charity care by approximately 20 percent. (SHIP will allow for the payment of at least a portion of hospital care.)

Basic preventive and primary care services are the foundation of SHIP. Services covered are outpatient and diagnostic services, 100 percent of health appraisals and well baby care, maternity care, 12 physician visits per year, and accident coverage. Inpatient hospitalization is limited to five days, or $2,500 per year. Excluded is any type of luxury services. SHIP is basic, no frills coverage.

Like Hawaii's gap group, SHIP's target population includes the unemployed, dependents of low-income workers, part-time workers, and seasonal workers. To be eligible to apply for SHIP, one must be a Hawaii resident, have an income that is less than 300 percent of the poverty level, not be eligible for any other type of health coverage through an employer, and have been without any form of health insurance for the prior three months. The last criterion was developed as a means to discourage people from shifting from other programs into SHIP.

SHIP members contribute to the program on a sliding scale based on their income. The fee contribution ranges from $0 to $60 for adults and $0 to $20 for children. Families are charged for a maximum of two children. Additional children are covered at no further charge. The state's contribution is approximately $500 to $600 per member.

SHIP has contracted with existing health insurance agencies to provide managed-care services to SHIP members. One is the Hawaii Medical Service Association, which is Hawaii's equivalent to mainland's Blue Cross/Blue Shield programs. Hawaii Medical Service manages the bulk of SHIP's membership via a fee-for-service network of over 700 participating physicians, or approximately 45 percent of the physician population in the state. The second agency is Kaiser-Permanente,

which has chosen to participate in SHIP only on the island of Oahu. Kaiser focuses on persons who are in transition between the Kaiser program and SHIP due to changes in employment situations. It is hoped that Kaiser will expand its participation in the program to the Neighbor Islands.

SHIP's first application phase began April 16, 1990, and closed in July 1990. During this period SHIP received over 5,500 applications. From these applications 4,100 qualified to be enrolled in the program. The profile of these first enrollees indicates that the majority of SHIP members belong to families of three or more members, most probably indicative of young family groupings. Their ages are clustered in the under-18 and the 30-64 age groups. The enrollees fall primarily into an income level that is below 200 percent of the poverty level, with the majority being below 150 percent of the poverty level.

The first application phase resulted in enrollments matching the proportion of the state population by island. Approximately 85 percent of Hawaii's residents live on Oahu, and the largest share of SHIP enrollees were from Oahu. During later enrollment phases, efforts on the Neighbor Islands and in rural areas will be intensified. Increased emphasis will be put on grass roots activities via community organizations, churches, and other social gathering places. In addition, SHIP plans to contact refugee groups to help in the translation of SHIP brochures and SHIP talks into other languages.

Public relations efforts encompass a variety of media. Electronic and print media were used to advertise the program. An interactive computer system, called Hawaii Access, which utilizes touch-screen terminals, is used. These terminals are located in low-income housing areas and shopping centers for use by the general public. And Department of Health employees volunteered to become certified SHIP registrars to assist with SHIP efforts statewide. SHIP is the first Department program that has used personnel from all divisions in this manner.

An interesting side note is that the SHIP application form may be the shortest form in government history. It was designed to be as user friendly as possible. It is a mere four pages long.

SHIP is a program of partnerships. It is a partnership between state government and families to meet their health care needs via a subsidized program. It is a partnership between state government and insurance companies to provide health care coverage. And it is a partnership between the insurance companies and health care providers to deliver quality, managed care. SHIP definitely exemplifies the Department of Health's philosophy:

> Health, that optimal state of physical, mental, social, and environmental well-being, is a right of all the people of Hawaii and a responsibility that must be shared by all.

To summarize, SHIP was developed to work in concert with the existing 1974 Prepaid Health Care Act, which mandates the provision of health care insurance and medical benefits for Hawaii's employees, and Medicaid. It offers a vital service for those who are ironically too rich for Medicaid yet too strapped to afford any health care coverage on their own. SHIP does not encourage persons' shifting to it from other existing programs, but fills coverage gaps that may exist for certain categories of people.

Hawaii, the Health State

Hawaii's tri-agency effort makes health care accessible for its citizens. Working together, the Departments of Labor and Industrial Relations, Human Services, and Health make Hawaii the Health State. Hawaii is achieving a major goal of a universal access care system.

The New York Proposal

Dan Beauchamp, New York State Department of Health

Universal New York Health Care, or UNY-Care, is the state health plan proposed by the New York State Department of Health but not yet adopted. We need to examine the dynamics behind universal health care and understand the role of the states in trying to lead the federal government to action. The economics of health care are driving Medicaid budgets so high that they even surpass education budgets. We need to look at some of the relationships of different factors that are involved.

Fundamental Conditions Underlying the Need for UNY-Care

Two interrelated factors compel New York to consider universal health care. First is a lack of insurance. Second is medical inflation. These factors interact with each other: medical inflation causes uninsurance and the cost of treating the uninsured adds to medical inflation.

In New York we recently negotiated a new hospital reimbursement bill that is far more generous to the hospital industry than it would have been if the whole system were encapsulated in some kind of universal system. Since it is not, the hospital industry in alliance with the Hospital Workers Union organized a powerful rally in Albany and achieved a very generous settlement. That increased reimbursement will cost every citizen of New York much more in health care costs. It will increase Medicaid program costs, and signals already predict some Medicaid program cutbacks. Further, unions will suffer forgone wages because employers will be trying to shift costs, and we will then see strike action, which is already beginning to happen in New York.

Another way of reflecting the inflationary pressures in the system is to note that the health costs of the United States increase at roughly twice the rate of the Consumer Price Index (CPI), which increases at approximately 4 to 5 percent per year. The private premium costs for health insurance right now are going up four times the rate of the CPI. The reason for this dramatic increase is that Medicare, through the prospective payment system, is slowly grinding a cost control process to the point that its costs are not rising very rapidly, but the costs are being shifted to the private payers. Consequently Blue Cross/Blue Shield and other private insurance payers are increasing premiums between 15 and 20 percent per year. Unless we do something about this pressure, the trend of premium rate increases at four times the rate of basic inflation will probably continue. How long do we think that trend can continue before all our private insurance is eroded away to the point that it is not worth very much?

Although the American health care system prides itself on being largely private, it regulates doctors more than any other health care system. The doctors are aware of this scrutiny. The reason why they are being regulated so intensely is the lack of the government's influence

over the total revenue flow of the system. Regulation is what you get when you do not have universal care.

A Comparison of Health Care Systems of Canada and the United States

In 1970 Canada and the United States each spent the same percentage of its gross national product on health care. Canada had just instituted its universal health care, but the United States only had Medicare and Medicaid. When Medicaid was passed, it was intended to assure that every poor person in the United States would be covered. The inflationary sprint in health care began. Three years later Congress quietly removed that promise of Medicaid. The United States now spends approximately 12 percent of its gross national product on health care, while Canada spends only 8 percent. Canada covers everyone, while the United States does not cover about 18 percent of its population. The reason Canada is able to control health care costs is that it covers everyone and all the money flows through the government. Because the system is universal, with no leaks in money flow outside the system, Canada is able to determine how much it will spend on health care in any coming year.

The second point in the comparison that is important relates to Americans' belief that government wastes a lot a money and private enterprise does not. In many areas this belief is correct. But in health care the opposite is true; our largely private approach wastes money. Some 23 to 25 percent of total costs of our health care system goes for some form of administration. Canada spends less than 10 percent on administration. Like our Social Security system, the Canadian health care system has low administrative costs. Canada has only one insurance company, unlike New York, which has a thousand. Further, Canada has a very simple reimbursement mechanism for physician services, the portion of their health care system that is fee for service. Our reimbursement system for physician services is very cumbersome. Finally, each hospital in Canada receives a budget each year. Canada does not use the diagnosis-related groups (DRGs) to get the elaborate cost controls that our Medicare system imposes upon the nation's hospitals and that we follow in New York State. The DRG way of controlling costs is very expensive, paper intensive, and personally intrusive.

Two Possible Solutions

Public debate proceeds as though we have only two alternatives. One is to expand the present system, as Hawaii is doing, until we approximate universal coverage by employment-based mandates. The other alternative is to move to a tax-based system similar to Canada's, which is the option being discussed widely in Ohio and a few other states. The United States would be very smart to adopt the Canadian system. Nevertheless, I do not believe that we will do so. Replacing all the private insurance in force would require raising approximately $200 billion in taxes. We do not have the capability of doing so in the 1990s.

Features of the UNY-Care System

Given this belief, I shall outline another proposal, the proposal for the UNY-Care system. In essence it is no more complicated than the automatic teller machine that you are accustomed to using. Every citizen of New York would have a card that entitles everyone to approximately the same coverage. Insurance would be made much more uniform than it presently is. We would eliminate medical underwriting. We would have very short waiting periods. We hope to have open enrollment and eliminate preexisting conditions, although we may have to wait for a year or so for these features. Everyone would have roughly the same level of coverage whether it is with Blue Cross, with Metropolitan, or with some plan for people who are out of the work force and that the state provides for them.

Electronic Claims Processing

The one card, the UNY-Care card, would replace all others. It would get a person into the health care system. A person would present the UNY-Care card at a doctor's office or at a hospital. With the electronic claims network being prototyped in the Albany area, the card would be slipped through the point-of-service terminal to determine whether the person is in the system. If one is in the system, from this point forward, no forms would have to be filled out and no claims would have to be filed. The individual is out of the claims submission business under this system. The provider has this responsibility, and it is done electronically. All paperwork is eliminated and the provider is paid immediately by means of a system that operates like a bank clearinghouse. Further, the adjudication of the claim is separated from the flow of money. In our present system much of the flow of money happens because someone looks at a claim, reads it, determines whether it has merit, and determines whether a check will be cut to a provider for services rendered. UNY-Care would have insurance companies advance pay once a week as a matter of policy to the single payer, who would immediately transfer payments to institutions. Institu-

tions would be encouraged to accept block payments of money on a prenegotiated basis, not just payment for each service that is rendered.

I have heard people describe the payment of a health insurance bill or a claim as being similar to a countdown for a thermonuclear exchange — from 10 to 0. Any mistake in the countdown requires starting over again at 10. Although an exaggeration, the analogy applies. A mature, adult society like ours should have no reason to run a major industry in this way. We should be able to pay doctors and hospitals in advance and audit the fact later. The electronic claims processing maintains a perfect audit trail by which adjustments can be made on a weekly basis. The point is to flow the money rapidly without paperwork to the provider and create the semblance of a single payer system even though many different insurance companies are still operating.

Controlling Health Care Budgets

Every other country in the world that has an advanced industrial society and a health care system has decided that a system such as ours is suicidal. They have created a single payer system — or its equivalent — that enables them to answer the most important question in the health care system at any time: How much should we spend on health care in total next year? That is the fundamental question. We in the United States cannot answer that question; and even if we could, we have no way to implement the decision.

The UNY-Care system in New York would cause all the money that flows through the system to run through a new government agency, a single payer authority. Not the New York State Department of Health, this new agency would probably consist of boards independently appointed by the legislature and the governor. It would determine on a budgeted basis how much the state could spend on health care in the following year. This agency would treat all the money flowing through the system like public dollars and would determine how much the system would grow in the next year.

The reason why medical inflation is so insistent can be traced to hospitals, which are the driving heart of the medical system. Hospital costs continually rise, although they are now being rivaled by physicians' costs. Both these sources of increase must be brought under control. The UNY-Care system would set hospital and physician schedules of fees. Perhaps our most important accomplishment would be setting up a statewide budget that would enable us to shift money from one sector to another.

Effect of the Single Payer Approach

A quick snapshot may show the importance of the relationship between hospitals and primary care. Hospital costs grow at a much faster rate than the Medicaid budget, particularly that portion of Medicaid that deals with primary care services. If the hospitals are gobbling up most of the resources, poor people who cannot get health care in nonhospital settings go to hospitals. They receive their care in emergency rooms and outpatient departments at rates that are much inflated over the rates for care they might receive in their own neighborhoods. We know of no ways to get enough funds to these sectors to change this balance. Each year the hospital budget in New York increases at a steadily higher rate, yet we cannot find ways of shifting monies to create new primary care settings outside the hospitals. If we could do so, the hospitals would benefit. They would not be so overcrowded, and their emergency rooms would not back up. They would have enough beds to serve the general population. By creating a single payer approach, the UNY-Care system would enable us to take money at the margin and shift it slowly into new sectors.

Through the single payer system, we can sharply reduce administrative overhead. We probably cannot become as efficient as the Canadians. Their system is so simple and easy to administer that it becomes a model. Nevertheless, we can probably cut our present costs in half. We are implementing a single payer demonstration project in the Albany area that will involve 12 hospitals. Next year we hope to bring in a number of doctors so that we can accelerate the payment of claims, reduce paper work, and show that moving to a non-paper-work system is possible. The Robert Wood Johnson Foundation has awarded us a grant for this demonstration project.

We do not want people paying doctors. We want people to understand that the best way of controlling costs is to have doctors and hospitals face one agent representing the public and not face thousands of people separately. When they face thousands, doctors and hospitals have enormous economic power. That power must be stemmed. The discipline of paying out of pocket does not work.

I believe that the single claims administration process that we are implementing in New York will become a driving force behind a fresh approach to health care and to universal coverage in the United States. Again, the heart of the idea is that if a single payer can be created and if all costs can be run through one single point, the possibility exists of using the power of government to get increased purchasing power.

Coverage

In New York we have taken a somewhat different approach than others have in determining what to include in the system. We decided not to have a detailed schedule of benefits that would become the core of the program. Instead, we tried to define a level of coverage that would include a very good public employees plan or a very good Blue Cross plan that would be a standard that approximately 85 percent of the state might currently enjoy. We would determine how much that standard would cost without deciding the specific details of what goes into it. We would use that figure as an estimating device to determine how much our total program would cost. We have not yet determined whether dental or eyeglass coverage would be included. We do have a cap on catastrophic coverage of $50,000 a year. Beyond that amount insurance companies would not be liable. The state would become the catastrophic coverage insurer for the entire state.

Effects on Insurance Companies

We believe that if insurance companies' liability is expressly limited, if their benefits are very much regulated, if open enrollment is a policy, if medical underwriting is prevented, then finally we will have an insurance industry that is worth something. At present the insurance industry is basically trying to avoid anybody who might get sick in 10, 20, or 30 years, an idea that is ludicrous. As others have said, if the insurance company is not there when we need it, why do we need it? The point is to insure all of us and to give us some security about health care, which deeply concerns every family in this country. We think we know how to do it.

Insurance companies are complaining that we are trying to put them out of business. They are apoplectic about the UNY-Care plan. Despite their fears, they will not disappear when we make them sell roughly standard products. Look at the oil companies. The various oil companies sell equivalent products and are prospering as companies. The insurance companies will do the same.

Two Approaches to Universal Coverage

UNY-Care would take two approaches to universal coverage. First, for the two-thirds of the workers that have jobs but no insurance for themselves and their dependents, we would set up a play-or-pay mechanism with employers for them to provide health care insurance. We would provide a tax that companies can avoid if they insure people. And we would subsidize small employers so that the cost would be a reasonable one.

Second, for people who are out of the work force but not poor enough to be eligible for Medicaid, the state of New York or those it contracts with would become the insurers. For people between Medicaid and 200 percent of poverty, we would provide the extra coverage that Medicaid involves, including preventive care and other services not normally part of insurance. Many times in the poorest parts of our state and the poorest parts of New York City, just having an insurance card is not going to be enough. Also needed will be social services, nutrition services, and other things that the Medicaid program provides.

Costs

We have money in the system to provide these extra services and the subsidies to small employers. Including federal dollars, we have a total state budget of approximately $50 billion a year. We already have a $1.2-$1.3 billion bad debt and charity pool that we pay to hospitals and a few other places for treating people without insurance. If we work that money and 2 percent of the $40 billion budget, about $500 million, we can do everything I have discussed. We are that close. Actuaries have confirmed that fact.

The question is whether we have the political skills to get the American people to admit that this problem is worth spending 2 percent more than they are currently spending. That is the big question of the 1990s. I also need to note that for people in other parts of the country, for example North Carolina, the cost would be more than 2 percent. In North Carolina the Medicaid program covers less than 30 percent of the people who are poor. Such is the case throughout the South and parts of the Midwest.

The Need for a Federal Government Plan

A question often asked is whether the states or the federal government should develop universal health care coverage. The answer is simple — the federal government. States have a much harder time doing it. Different states will develop different programs with different kinds of cost constraints. Any state that tries to innovate faces the danger that half the state will run to the neighboring state for a particular service or procedure and the danger that the physicians will move. Those dire consequences would not happen in a system of the federal government. In reality we are hoping that as we get closer and closer to this kind of program and as other states do so, the federal government will rouse from its great slumber and we will actually see a universal program American style.

The Ohio Proposal

Dennis Roberge, Ohio Education Association

Although numerous issues have been before the Ohio Education Association over the years, the one that seems to be perpetual for us is health care and health care costs. Numerous matters interact with this issue. Who pays and who does not? Is health care a privilege or a right? Currently those who have it and pay for it pay for its use by other individuals who do not have it. What is the political impact of this reality? What are some political impacts and realities that are occurring in Ohio and a number of other states as well as on the national level?

The Scope of the Health Care Issue in the Labor/Management Arena

Health care, which emerged as an issue in the 1980s, has become the hottest topic in the labor-management arena. The broad subject of health care encompasses all the issues related to individual income. It involves the designing and financing of health care coverage plans for active and retired employees as well as the nonworking populace. During contract bargaining, workers in this country have forgone wage increases in order to maintain and improve health care benefits. Health care coverage needs to be viewed essentially as a wage and income issue rather than solely as a health benefit issue for both active and retired employees. A majority of our members, as well as our union brothers and sisters, believe that when it is needed, access to health care coverage is a basic right for all Americans.

The Extent of Lack of Coverage

The decade of the 1980s resulted in a piecemeal tinkering with U.S. and Ohio health care systems. Different levels of government tried to deal with the inability of individuals, employers, and employees to obtain adequate and quality health care coverage. The growing number of individuals, employers, and employees who are unable to obtain or to afford quality health care insurance is placing a tremendous pressure upon employers, labor unions, and elected officials. In Ohio, health insurance is estimated to be unavailable or not affordable for over 15 percent of the state's population. This reality means that 1.7 million Ohioans are without health care coverage.

Nationally Ohio ranks sixth in the number of people who do not have health insurance. In the spring of 1990 the Ohio Department of Health reported to the Ohio General Assembly's Task Force on Health Care that one in every five schoolchildren was without health care coverage. Most of the individuals who lack health care insurance are in the work force. Many who lack health care coverage are not poor enough to qualify for Medicaid coverage in Ohio, but have minimum-wage or low-income jobs that do not provide insurance benefits

or do not pay wages that allow the individual to be able to afford to purchase health care. Surprisingly this reality is true even for workers in the health care industry. Many are working as maintenance, cleaning, and cafeteria employees and, in some cases, are confronted with having to choose between food for their families and copayments for health care benefits. Each month that goes by, more individuals fall out of coverage, and more and more individuals cannot afford to continue paying for health care coverage.

As others have noted, the Census Bureau estimates that 32 million Americans, or 17.4 percent of the nation, are uncovered for health care. Further, initial Census Bureau data indicate that as many as 63 million Americans were not covered in 6 of the last 24 months when they were switching or between jobs or were changing to or from Medicaid or other types of health care coverage.

Uncertainty about Coverage in the Future

Concern and fear exist both in the public and in the private employment sectors that access to health care coverage is not assured in the future to active employees or to current and future retirees. Employees who are covered by health benefit plans currently do not want to be tomorrow's uninsured or underinsured individuals. These employees are very concerned about the possibility that the levels of health care coverage provided by their employment and through their retirement systems will be reduced or, worse yet, not provided at all. The fear of not having adequate health care coverage appears to be common among all the citizens of the country regardless of their income levels.

Pressures on Politicians

Ohioans, in the General Election on December 7, 1990, decided the political composition of the state's apportionment board, which comprises the governor of Ohio, the secretary of state, the auditor, one legislator from the House, and one legislator from the Senate. Those individuals will determine the boundaries of all the legislative districts in Ohio for the next 10 years. Politically active interest groups used the candidates' motivation to direct them to frame their positions on health care and other issues. One of the most active multiorganizational special interest groups in Ohio in the health area is the coalition called UHIO, that is, Universal Health Insurance for Ohio. Throughout the campaign legislators and candidates for state offices faced intensified questioning and endorsement questionnaires in meetings about their positions on health care legislation for the coalition of Ohio's statewide member organizations of retiree groups, human service groups, and labor groups. The result of this organized and direct political activity is being sorted and analyzed for use in the next session of the Ohio General Assembly.

Pressures also come from other quarters. Ohio legislators are quite aware that retired employees are politically very active and are increasing in number. Senior citizens in Ohio take the time to write and to visit their elected officials both in the home district and in the capital.

State legislators in Ohio have a further concern about employee health benefits. Unlike the members of Congress, who enjoy federal government coverage, Ohio legislators are covered under the same health care programs that all state public employees have in Ohio. Retired legislators are also covered under the same health benefits program as all the state's retired employees.

A Brief History of Retiree Health Care in Ohio

A brief history of what has happened in the Ohio public retiree arena in health care would be helpful at this point. The initial health care coverage for public employee retirees in Ohio began in the mid-1960s as it did in a number of other states. In the 1967-68 Ohio General Assembly session, the legislature passed a bill that allowed the retirement systems in Ohio to collect premiums for health insurance. The retirement systems chose the health care coverage levels, contracted with providers, and collected the premium fees.

The passage of House Bill 430 on November 20, 1974, changed this practice; it added health care as a benefit provided to public employees by the retirement systems. The legislation authorized that after January 1, 1975, the retirement systems could pay for all or part of the premium costs of health care coverage for retirees. It was permissive legislation. The health care benefit that was provided was initially a pay-as-you-go benefit and has not been a fully prefunded benefit in any of the state retirement systems to date.

In the years immediately after the retirement systems established paid health care benefits, inflation, not health care cost, was the major concern of the system. At the time that health care benefits were provided to the public employee retirees in Ohio, actuaries across the nation had made an assumption that the federal government would pass legislation that would implement a national health care program in the near future. In light of this assumption and the sparse data that were available on the cost of health care, the actuaries kept the

assumptions about the future cost of health care coverage extremely low. The initial results of this assumption were that the retirement systems' health care coverage premiums were inexpensive and relatively easy to administer. Since its inception, health benefit coverage for retirees has been perceived as an important part of the total retirement program benefits. Many of the public employees believe it is a vested benefit right.

Changes Causing Concern

Some of the retirement systems in Ohio have begun cost shifting through increased deductibles and reimbursement caps. The irony is that a state government and its public employee retirement systems that only 15 years ago were dedicated to providing adequate health care coverage for public employees now find themselves searching for mechanisms to reduce costs through erection of barriers to retirees' access to health care.

Any modification in health care benefits has to be considered in relation to the fundamental issues of access, quality, and adequacy of the health care benefit option. Under the Reagan Administration, the federal government forfeited its role as a chief policymaker in domestic matters, a role that has fallen mostly to the states, which are now trying to tackle one of the nation's most complex, costly, and controversial problems.

State and local governments' concern about health care is economic. Steep increases in annual costs of public employee health insurance premiums have caused both state and local governments to be concerned with the bottom line. That bottom line is to determine how the state will raise the monies necessary to fund programs that will or can resolve the health care dilemma.

Today health care costs in the United States are just under 12 percent of the gross national product. They are not expected to level off until they are somewhere between 15 and 20 percent of the gross national product. For the first time in the history of Ohio, the 1988 state budget allocation for Medicaid exceeded the total budget allocation for elementary and secondary schools. As the costs and demands for health care continue to outstrip the nation's willingness to pay for it, states have increasingly felt the pressure to be the payer of last resort that gets stuck with the costs the federal government and private insurers refuse to pay. This problem is causing consumers, government officials, labor leaders, and business representatives to debate what used to be unmentionable alternatives in the health care arena, such as universal health care, required insurance coverage, and even rationing of health care services.

Newly Enacted and Pending Legislation in Ohio

Equal access to quality health care for all citizens has become an important public policy issue for politicians in all levels of the Ohio government. Health care benefit reduction and in some cases outright elimination of those benefits continue to be considered by many employers as well as some of the state retirement systems.

Programs to solve the health care crisis will inevitably demand more and more state resources. Nevertheless, state legislators are resistant to any increases in the payroll tax, the big "T" word. Three bills addressing the problems of the uninsured and the uninsurable were introduced in the last session of the Ohio General Assembly. By enacting House Bill 111, the Ohio legislature provided $2.8 million for three pilot programs to begin the study of how Ohio should provide sickness and accident benefits for the uninsured worker.

A second piece of legislation, House Bill 188, would establish a state insurance "Risk Pool" to provide coverage for individuals who have been denied health insurance or have been offered coverage at excessive rates because of existing medical conditions. The plan would be funded by individual premium payments and supplemented by a $2 million appropriation in the budget over the next two years. Premium rates would be based on current standard rates and would be adjusted on a sliding scale according to the individual's income. This bill still sits in committee. Fourteen states have passed similar "Risk Pool" legislation.

The third bill would provide for the establishment and operation of a universal health insurance program in Ohio. The statement of purpose in the bill is that "the Ohio Universal Health Insurance Plan is hereby created for the purpose of providing a single, publicly financed, statewide insurance program to provide comprehensive coverage for all necessary health care services for all residents of this state." Private health insurance would be phased out over a period of three years.

The Ohio Universal Health Insurance Plan would provide all necessary medical services for the maintenance of health; for the diagnosis, treatment, and rehabilitation following injury, disability, or disease. Services would be provided with no copayment, deductible, or insurance paperwork. The bill also specifies that coverage for durable medical goods, medical supplies, and selective devices would be included. Prescription drugs would be provided with a copayment. Basic vision care and equipment would be available up to the age of 18. Ambulatory mental health and substance abuse treatment would be provided on a limited basis, and a

special prevention fund would be set up to ensure funding for community and individual preventive services. The intent of the legislation is to provide a single payer in the state of Ohio and to allow a continuation of the individual's selection of practitioners and providers in Ohio.

The initial reaction to this bill for universal health insurance was very negative. It was put into committee and then into subcommittee. The insurance industry certainly did not buy into this proposed program. In fact, Blue Cross/Blue Shield has spent $174 million to develop a data base to support its position that this plan should not move forward. The Ohio universal plan would provide that private insurance carriers could not duplicate anything that is provided within the plan. They would be allowed to sell insurance that would provide supplemental coverage for those areas that are not covered within the universal health plan. The insurance industry, the hospitals, and the physician providers have all been promoting the present system and working against the proposed changes offered in the Ohio Universal Health Insurance Plan.

Lobbying by the UHIO Coalition

In contrast to this lobbying against the legislation has been the growth of very effective lobbying for it. The UHIO coalition held an immensely successful rally at the capitol. What we learned is that the populace is far out in front of the political leaders and perhaps of the Association leadership on this issue.

I believe this issue will be resolved in the 1990s and perhaps even before 1995. Concern continues to evolve around what is happening to assure that individuals will have health care coverage. The very existence and the actions of the UHIO coalition exhibit the extent of attention, interest, and commitment that groups have developed on the issue. The UHIO coalition consists of a large and varied group of organizations. The teachers are in it, as are the Association of Social Workers, Communication Workers of America, and the Catholic Conference of Ohio. The Ohio Association of Nurses and the Teamsters are at the table discussing and working on the bill. The Coal Miners and the AFL-CIO are active members. The Ohio Association of Public School Employees and the Ohio Civil Service Employees Association, two groups that at times our Association has opposed, are present. The American Federation of State, County, and Municipal Employees and the Governor's Office of Advocacy for Persons with Disabilities participate. And both the Gray Panthers and the American Association of Retired Persons are in the coalition.

The Northeast Ohio Coalition for National Health Care is the lead group that began UHIO several years ago when five retirees lost their insurance. Its initial interest was in national health care. The Northeast Ohio Coalition for National Health Care has grant funding from a number of agencies. It recently took 10 Ohio legislators and business people to Canada to observe the Canadian system and to work with its agents to understand how that system works. Participants learned that a recent poll revealed that 85 percent of the people in Ontario do not want their health care system changed and that the chief negotiator for the medical association for the physicians says they also do not want the system changed. What they now want is binding arbitration with the government to make the final decision about rates.

The strength of the arguments and the lobbying is growing. The base of the coalition is becoming larger with each week. It formally became a statewide unit on September 20, 1990. After that formulation, it grew in size by an additional 14 organizations, and 5 regional subunits have been created.

The Challenge to the Association

The Association needs to take a close look at what is going to happen in health care. We need to become the leaders in determining what will be in the pieces of health care legislation. The federal government at present has no intention of bringing any national health care legislation forward. Legislation will be piecemeal across the United States in accordance with need, demand, and pressures by the states before it becomes a national issue to be resolved in federal legislation.

Proposals for a National Health Plan
The Physicians' Proposal

Steffie Woolhandler, Harvard Medical School

We have a crisis in our health care system both in costs that are rising completely out of control and in the increasing number of uninsured people, now estimated at 37 million, a number that really underestimates the problem. A recent survey found that fully one-quarter of all Americans have been uninsured at some point over a 28-month period for reasons such as changing jobs. Another part of underestimating the problem is the number of people who are underinsured. They have some health insurance, but insurance with so many gaps and deductibles that they still cannot afford medical care.

The Uninsured and the Underinsured — Unmet Medical Needs

Who are the underinsured? Many of them are elderly who, despite the existence of Medicare, are paying for more than 50 percent of their health care bills out of pocket. The average elderly person spends 18 percent of total income on health care despite the existence of Medicare or Medicaid. Another group of the underinsured includes 20 to 50 million middle class Americans who have health insurance but who would be bankrupted by a major illness because their insurance has gaps, deductibles, and limits. Also 5 million young women of child-bearing age in this country have health insurance that does not cover maternity benefits.

Access to health care is a problem for many people who have insurance. Studies reveal that 12 percent of people with health insurance report a major financial problem due to illness in the past year. Fully 19 percent of people with health insurance have had a serious illness but did not see a doctor about it. Further, 21 percent of people with health insurance report no regular source of care. And 15 percent of people with health insurance have needed medication, nursing care, or other health service but were unable to get it. The problem of underinsurance is serious. Many people who have some insurance still cannot afford medical care.

What happens to people who are uninsured or underinsured? One example concerns a woman who visited a private hospital's emergency room after being hit by a truck. Because she had no health insurance, she was transferred in an ambulance without a doctor or a nurse in attendance to a public hospital nearly 30 miles away. This unfortunate woman was treated this way when she had suffered multiple fractures of her bones, of her pelvis, and of her ribs. Further, her blood count had fallen from 38 to 28 percent despite transfusion of two units of blood, which indicated severe internal bleeding. This type of incident happens about 300,000 times a year in this country.

Even such dramatic incidents in emergency rooms are only the tip of the iceberg of unmet medical needs. If we look at preventive care for women, we find that lack of health insurance is the most powerful predictor — of

failure to have one's blood pressure checked, of failure to get a Pap smear, of failure to have one's breasts examined by a physician or a nurse, of failure to have one's eyes checked for glaucoma. Lack of health insurance is the most important predictor of failure to receive needed preventive care. In fact, the predictive power of lack of insurance actually increases when we use multivariate analysis to control for such factors as urban versus rural residence, education, race, and others.

From another perspective, if we look at the proportion of people in poor health who actually see a doctor for their health condition, we find that, in fact, poor people do not see doctors as much as the well-to-do when they are sick. Clearly this difference is due to the lack of health insurance.

The proportion of Black women who receive no prenatal care before the end of their pregnancies is very high. Only 60 percent of Black women in the United States receive adequate prenatal care. The proportion of people failing to receive adequate prenatal care was declining until 1980. Beginning in about 1980, the proportion of those failing to receive it began to increase. This reality may well be one of the explanations for our high post-neonatal and infant mortality rate, which has also begun to rise since 1980.

If we look at the causes of excess mortality among Black females, we find the following: cardiovascular disease, cancer, infant death, and diabetes. These excess deaths are due to causes that medical care can treat. They are not due to crack addiction or gunshot wounds, the things that are used to belittle the problems of the poor. They are due, by and large, to medically treatable conditions. A similar kind of disgraceful reality is revealed when we compare the survival rates of men in Harlem and men in Bangladesh. A Black man in Harlem has less chance of surviving than a man in Bangladesh.

I have been presenting data on poor health status by race. Unfortunately we do not keep statistics in this country on poor health status by social class or income. So we have to look at data on Blacks and use that information as a proxy for low-income people, whether Black, white, Hispanic, or other.

Effects of Rationing Health Care with a Surplus of Resources

In 1990 in the United States, we are rationing medical care. Fully one-quarter of all Americans are uninsured or underinsured. They are often denied care when they are sick or when they need preventive care. And they are sicker and they die younger than the affluent and the well insured.

This situation would be sad if the United States had a shortage of medical resources. But, in fact, the United States has a surplus. At this point one of every three hospital beds in this country is empty, and we hear about an impending surplus of physicians and other medical personnel. We are actually rationing the surplus. We are denying care to Americans in the face of an excess of hospital beds and an impending excess of physicians.

The problem of the surplus of medical resources goes beyond the issue of access to care because more is not necessarily better. An excess of beds or of surgery units does not mean better care. It may mean worse care. For example, studies reveal that hospitals that do fewer than 200 procedures in certain types of surgeries, such as prostate and vascular surgery, actually have higher death rates than others. The hospital has a surgery suite but does not often use it. Then the death rate tends to be higher because the personnel are not able to maintain their expertise.

In the state of California, fully one-third of all hospitals that perform open-heart surgeries do too few procedures to maintain their competency. Having these excess surgery suites actually lowers the quality of care. In Des Moines, Iowa, two different hospitals do renal transplants. One does 8 cases, and the other does 15. Those are too few cases to maintain the necessary quality and the competency of the personnel involved. Patients would be much better off if they were sent to a university hospital 100 miles away that does 70 cases and maintains the expertise. So we have a surplus of resources in this country and a serious problem of quality of care.

The Problem of Excess Surgery

Another problem is the excess surgery in our society. An old saying notes that if you go around with a hammer in your hand, everything starts to look like a nail. If you have a cardiac surgery suite that is empty and you have surgeons who do not have work to do, those surgeons start looking for extra work. In fact, the Rand Corporation looked at coronary bypass grafting (open-heart, or bypass, surgery) to see what proportion of all bypass surgery in this country is appropriate. The study found that only a little more than a half of the coronary artery bypass surgery in this country is clearly appropriate. One-third of the coronary artery bypass graft surgery is equivocal, and 14 percent is clearly inappropriate. We are doing a lot of inappropriate and equivocal coronary bypass grafting. Note that this particular surgery is the most prominent elective procedure in the United States, and it costs about $50,000 a case.

The situation is even worse with carotid endarterec-

tomy, in which a surgeon cleans out the arteries in the neck of a patient. Only one-third of carotid endarterectomies in this country are clearly appropriate. Another one-third are equivocal, and one-third are clearly inappropriate. Again we have a problem of excess surgery related to the surplus of resources, resources that are only available to the well insured.

Cost Issues

Next let's look at the issue of cost. Does the surplus of medical facilities drive down cost? A common teaching is that competition will drive cost down. But competition in the medical marketplace means duplication, more than one hospital in a given market area. Hospital market areas in which competition exists actually have higher costs than hospital market areas with no competition.

The number of health administrators in this country is rising at four times the rate of the increase in the number of physicians. Perhaps the administrators are in place because rationing a surplus is very difficult. A surplus of beds, a surplus of doctors, and a great many people who have medical needs require a lot of work to keep them apart. These administrators have to make sure that only the well insured get those resources and that poor people, the uninsured, and the middle class underinsured do not have the access.

Basic Requirements and Effectiveness of the Canadian System

These realities are very depressing, but some other systems do work quite a bit better than the system we have in the United States. Physicians for a National Health Program, of which I am a member, has over 3,000 physician members in all 50 states. We have been advocating a Canadian style national health program for the United States. Although we do not think that Canada's system is perfect, we do think that it would be a tremendous improvement over the present system in the United States.

The Canadian National Health Program is quite simple and has only four provisions. The federal government provides money to the provinces if they set up a provincial health program that meets the following requirements:

1. *Universal coverage that does not impede, either directly or indirectly, whether by charges or otherwise, reasonable access.* This requirement has been interpreted to mean that everyone has completely free access to care with no copayments and no deductibles.
2. *Portability of benefits from province to province.* A person from Ottawa who gets sick in Québec must be covered.
3. *Coverage for all medically necessary services.* This requirement has been liberally interpreted. It includes transplants, preventive care, and so forth.
4. *Publicly administered programs.* Programs must be publicly administered by a nonprofit administrative body.

The Canadian National Health Program does appear to be improving access to health care for the Canadian people. In surveys that were conducted before and after the enactment of the Canadian program, a population was asked several questions, two of which were as follows: Did you have serious symptoms? If you had serious symptoms, did you see a doctor? Before the enactment of the national program, only a little more than 60 percent of people with serious symptoms saw a doctor. After implementing the national program, well over 75 percent of people with serious symptoms were able to see a doctor.

Canadian and American Comparisons

Barriers

In a recent survey Canadians and Americans were asked whether they had found barriers to receiving medical care. When asked whether they were unable to get medical care because of a financial barrier, 7 percent in the United States reported a financial barrier, whereas only 1 percent in Canada reported that barrier. When asked whether they experienced a nonfinancial barrier to care, such as a waiting list or an inability to get an appointment with a specialist, Americans were twice as likely as Canadians to report a nonfinancial barrier to care. Access for Canadians is better both from a financial perspective and from a nonfinancial perspective.

Hospital Admissions

When we compare hospital admissions for medical conditions that do not require a surgeon, such as myocardial infarction, access for the elderly to hospital admission is equal in Canada and in the United States. Almost identical rates between the two countries also exist for the elderly in hospital admissions for surgical procedures of the heart. The one surgical procedure for

which Americans receive significantly more surgery than Canadians is coronary artery bypass grafting. The lower number of Canadian surgeries in this area is not necessarily a bad thing.

Medical School Applications

Medicine in Canada is a very prestigious and desirable profession. In Canada four applications exist for every medical school place; in the United States that figure is 1.6 applications per medical school place.

Efficiency and Inefficiency in Controlling Costs

Finally, Canada has been much more successful than the United States in controlling overall health care costs. After the enactment of Canada's National Health Program, health care costs as a proportion of gross national product (GNP) leveled off. In the United States the costs keep going up and up. They are now at approximately 11.4 percent of GNP and are projected to increase to 15 percent of GNP by the year 2000. That projection is optimistic.

How can Canada keep its costs down? The answer is efficiency. People do not like to think about efficiency, but it is the key to understanding how Canada can provide high quality care without copayments and deductibles to all its citizens at a lower cost than we pay in the United States. More specifically, the key is administrative efficiency. A now outdated survey revealed that administration consumes 23 percent of total health spending in the United States, but only 13 percent in Canada. I have just published updated data. We found that the United States is now spending 29 percent of health care costs on administration, while Canada has reduced its percentage to 11.3 percent. This difference represents a lot of money that can be made available for medical care for people who need it. As well, Canada saves money by controlling capital costs.

What is the basis of the inefficiency in U.S. health care administration? We spend a lot of money on billing. The billing apparatus in U.S. hospitals is extremely expensive. In 1983 U.S. hospitals spent 18 percent of their total costs on billing and administration whereas Canadian hospitals spent 8 percent. In 1986 U.S. hospitals spent 20 percent of their total costs on administration.

Let's look at insurance overhead. Over 1,500 different insurance companies operate in the United States. The average private health insurance policy in the United States has an overhead of 12 percent. For every $1 paid to a private insurance company in the United States, only 88 cents come back as medical care. The overhead in Canada's program is about 1 percent. Even the overhead on U.S. Medicare and Medicaid is less than 3 percent. The administration of private health insurance in this country involves a tremendous amount of waste and inefficiency.

Attitudes toward the Two Systems

Would people in the United States prefer a Canadian style system? A random sample of the U.S. population was recently asked:

> In the Canadian system of national health insurance, the government pays most of the cost of health care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals. Under the Canadian system people can choose their own doctors and hospitals. On balance, would you prefer the Canadian system or the system we have here in the United States?

Nearly two-thirds of Americans said that they were quite sure they would prefer the Canadian system.

Canadians were asked a similar question in which the U.S. health care system was described to them. Only 3 percent of Canadians felt that they would trade what they have for what we have here in the United States. Note that the Canadian system prior to the implementation of its national health program 20 years ago was virtually identical to the system in the United States. As a result most Canadians do have experience with the style of system in the United States, and they do not feel that they would ever want to go back to it.

Looking at physicians' opinions, we find that even among American physicians considerable support for national health insurance exists. Old data collected in the mid-1970s and published in 1986 reveal that 56 percent of American physicians favor some form of national health insurance. My experience with physicians suggests that their level of support for national health insurance is now quite a bit higher. A curious finding is that 74 percent of physicians think that most other doctors oppose national health insurance. This difference may have something to do with the influence of the American Medical Association (AMA), organized medicine, which has been pushing its views as representing those of physicians generally. I do not think that it does.

If so many people support national health insurance for this country, why don't we have it? If I were a private insurance company and I were being paid 12 cents on the dollar for insurance administration, something that could be done for 1 cent on the dollar, I would be opposed to change as well. The private insurance industry is

spending a tremendous amount of money at the national level to block national health insurance.

I am probably cynical enough to be pessimistic about the possibilities for national health insurance in this country were it not for the corporate allies that we have the potential to develop in this struggle. Chrysler corporation is spending $700 per car on health benefits in the United States versus only about $200 per car in Canada. Further, health spending as a percentage of corporate profits is going up and up. The amount of health spending is approximately equal to the amount of corporate profit.

Problems of Employer-Mandate Proposals

Consider employer-mandate proposals. Most of the proposals being considered seriously in Congress are some form of employer-mandate proposal. None of them will solve the health care problems we face in this country. Some of them are the Pepper Commission report, the AMA proposal, and a proposal by the National Leadership Commission. An employer-mandate bill was actually passed in 1988 in Massachusetts. Even Richard Nixon's proposal in 1974 involved an employer mandate. These proposals have been around for a long time. They were a bad idea in 1974 and they are a bad idea in 1990. Let's consider why.

Employer-mandate proposals have two key features. The first is that employers are mandated to provide coverage or to pay a tax, and some exceptions may exist for small businesses. These exceptions differ from plan to plan. The provision is basically play-or-pay. The employer provides insurance or pays a tax. The second major provision is that all these proposals expand Medicaid or some similar public program to pick up the remaining uninsured. Some of them also have two additional provisions — some sort of small insurance market reform and some sort of malpractice reform. Nevertheless the first two features are the most common.

What are the advantages of employer-mandate proposals? First, they would cover most of the uninsured. Second, they are financed primarily through premiums rather than taxes. However, if the government requires a small business owner either to spend $1,800 on health insurance or to pay a tax, that business owner knows that the premium payment is really a form of a tax. But from a Congressional point of view, calling this payment a premium and not a tax will help to ease the burden. Finally, the major advantage supposedly is that employer-mandate proposals do minimize opposition from private insurers. Most of the new insurance under an employer-mandate proposal would be purchased from the private sector, an idea that the private sector likes.

Employer mandates have two major disadvantages. First, they fail to address the problem of underinsurance. The underinsured are those of us who have some health insurance but still find our copayments and deductibles difficult to meet when we get sick. Because employer-mandate proposals buy insurance in the private sector, they would increase bureaucratic costs. Second, they have no effective cost containment. In the present fiscal climate, talking about proposals that will vastly increase either government outlay or private outlay makes no sense. The Pepper Commission estimated that its proposal would increase total costs by between $40 and $58 billion in the first year, with a 9 percent increase thereafter.

I think that, in fact, we can provide good and decent health care to people in the United States with the Canadian model for what we are now spending. The 11.4 percent of the GNP that we spend on health care is enough to provide high quality care for all Americans, but we have to spend it efficiently.

The Tax Reform Model

Edmund Haislmaier, The Heritage Foundation

I would agree with two points that Dr. Woolhandler made. One is that the present system is a mess, is not working, and needs to be changed. The other is that mandated, employer-provided health insurance proposals are not the way to fix the system. I could add to her last comment some analysis of my own on how the mandated health insurance schemes proposed by the Pepper Commission and others are as bad, if not worse, than what we have now.

Some Basic Principles of Economics and Ethics

Before presenting the details of the Heritage Foundation's proposal, I would like to put the debate over health care financing into some perspective. Reviewing a couple of basic principles of economics and ethics will allow us to do so.

The Role of a Free Market

Let's begin by considering the role of markets and health care. With regard to any goods or services, a freely functioning natural market has a number of advantages. First, a free market is the most effective method people have found to allocate goods and services according to their perceived value. I say "perceived value" because value is inherently subjective. Different providers and different consumers will all have different ideas about what any given item is worth. Watch an auction and then discuss the results with participants to see how varied are the perceptions of both buyers and sellers about value. Different people have very different ideas about what value is; all of us do. These ideas about value are products of very complex, very personal, very individual decisions.

The market provides an orderly way for these various individuals to reach agreement about value. Providers and consumers use prices to communicate to each other their perceptions of value. When a buyer and a seller agree on a price, they have in effect agreed on something's value. The reason this concept of value is important in relation to health care policy is that most of us, if not a large majority of us, feel that the American health care system today does not provide good value.

We can go through all sorts of statistics about the percentage of the gross national product that we spend on health care and so forth, but what do these numbers really mean? Can anyone here give me the optimum percentage of its gross national product or per capita income for this country or any other country to spend on health care? We are currently spending about 12 percent of GNP on health care. Is that too much? Is that too little? We all seem to think it is too much because we are spending more than everybody else in the world. On the other hand, Britain is spending 6.5 percent and observes that Canada is spending 8 percent. Obviously, the British think all their

problems are due to the fact that they are not spending enough.

What is the optimum? I do not think anybody can come up with it. We are using these numbers as a proxy for saying that we do not think we are getting a good deal. Usually when people talk about the cost of health care, they say that we spend all this money and only get "X" or do not get "X." We have poor access; not enough people get the treatment they should have. We have poor quality; we have operations that should not be done. We have poor outcomes; we have high infant mortality. In other words, the benefits do not match the costs. All of this is a question of value.

The second advantage of markets is that they encourage and reward efficiency and innovation. Although in this country we may have considerable innovation in developing new treatments, we have a lot of room for innovation and efficiency in the ways we deliver and finance health care. Nevertheless, just because we have high administrative costs does not mean that we need to go to a nonmarket system. We may want to see whether some sort of distortion is rewarding high cost. Normally the first thing that one does in a competitive market is to try to find ways to cut overhead if one wants to stay competitive. Why aren't insurers being encouraged to do that?

I would argue that the one exception in this area proves the rule. Where do we see the greatest innovations in health care? We see them in the technological sphere — in the development of new procedures, new equipment, new machines, new applications of electronics and lasers, and other new technological advancements in the field of medicine, such as the research and development of pharmaceutical companies for new drugs. The drug industry in this country spends more than the National Institutes of Health on research and development. We see the most innovation precisely in the areas where health care is least distorted, where a freer market exists.

Where we do a bad job is in the area of secondary innovation, in being innovative in applying our medical knowledge and technology in the most efficient ways. In short, I would argue that a greater reliance on market mechanisms in health care, as in any other area, is the best method for encouraging innovation and efficiency and eventually obtaining good value.

The Role of Insurance in a Free Market

Let me digress for a moment and talk about the role of insurance because that comes into play also. Insurance in a freely functioning market is a way to account for uncertainty, to even out things, to make things predictable. You don't know if your house is going to burn down. You don't know if you are going to have a car wreck. You don't know if you are going to need an appendectomy. What you do know is that if certain things occur and you are not prepared for them — you do not have large amounts of money in the bank — you are going to have trouble dealing with them or purchasing things that you need to replace a loss.

Because insurance evens out that unpredictability, people buy it voluntarily and freely in the market with no government interference for all sorts of things. Lloyds of London will insure just about anything for the right price. And that price is a calculation of the probability of something occurring versus the liability of its occurring. In other words, if something is very expensive but very unlikely to occur, you can probably get a pretty cheap premium for it. If something is very likely to occur, but is even inexpensive, you will have to pay. Imagine what would happen if your auto insurance said that it would pay for all your flat tires, oil changes, problems with your distributor cap, fan belts breaking, and things like that. Such things will be very expensive to insure because they are much more predictable.

Insurance also acts as an economic cushion, regardless of one's economic status. For example, consider two people holding the same homeowner's insurance. One may be much wealthier and have greater assets than the other, but their same policies act as an economic leveler. With the policy, each can replace a loss. We sometimes try to push insurance beyond its natural limits. We see the redistributive effect of insurance. We see how insurance makes things predictable. And then we try to make it achieve ethical objectives. We try to turn it into a system of cross subsidies.

The Role of Ethics

One might say that all this is fine and good, but a free market in health care and insurance costs would create other problems. For example, some people would not be able to afford care. Some people would be unfairly burdened with high medical costs as a result of being afflicted with some condition beyond their control. Recognize that when we note these problems we are crossing the line from economics into ethics. A very important distinction exists. In a large measure this entire debate over how to fix our health care system revolves around a couple of fundamental ethical issues or decisions.

We as a society, and indeed most societies in the western world, have decided that the poor should not be denied care simply because they do not have the money

to pay for it. Further, we have decided that the sick should not be unduly burdened with the cost of their care. These are ethical decisions. They are ethical decisions that I support. If we accept these ethical decisions, then the key policy question becomes how best to subsidize the needy, the poor, the sick, and the disadvantaged.

Problems in Subsidizing Health Care by Artificially Lowering Costs

If we accept these ethical judgments, how do we subsidize the poor and the sick? We can do so by trying to lower prices artificially, by trying to force insurance beyond its purpose. For example, we could say that although a particular person costs $5,000 to insure, we will only allow the insurance company to charge $3,000. Various ways exist to make such adjustments. National health care is one way, whether it is the British model or the Canadian model. National health care is one insurance system for everybody that is funded by taxes. The employer-mandate model also tries to do the same thing. Community rating says to insurers that they can only charge premiums within a particular range. Regardless of the approach, we are actually trying to lower artificially the price for certain groups of people. The result is that all these approaches generate new problems. One alternative is to supplement the incomes of the disadvantaged through vouchers or some other means. Yet another approach is for the government to pay the hospital and the doctor directly for treatment of the poor.

Problems of Mandated Benefits

Mechanisms that attempt to lower prices artificially may look good, but they generate new problems. First, if we artificially lower the cost for one group of people, we artificially raise the cost for another group. Those people with the higher rates have a powerful incentive to try to get out of the system, and that situation is what we see today. In this regard state-mandated benefit laws are well intentioned. They say to insurers that they must cover both X and Y. But what they do in aggregate is to raise the cost of health insurance. We now have approximately 800 laws like this on the books. Studies show that if we would simply wipe the slate clean and get rid of all these mandated benefit laws, the price of insurance would drop to the extent that one-fourth of the uninsured would be covered.

As health care costs march upward, the numbers of the uninsured go up also. Who are the uninsured? They are people who have been priced out of the market. To get them to buy back into the market, somehow the cost must be lowered.

Another problem that arises when we try to lower costs artificially is that we have to keep in the system people who are paying higher prices. Some people get lower prices; some people get higher prices. Those paying higher prices cannot be allowed to get out. We need their money to subsidize someone else who is paying lower prices.

Problems of Attitudes

What happens to attitudes? When people need health care, when they meet their deductible, most of the health care is then free or at very low cost. Then they have the incentive to use the system as much as possible to get back their share. This attitude is prevalent in national health care plans. People in national health systems say that they go to the doctor every time they get the sniffles because they pay taxes and want to get their share back. What they do not understand is that for the system to work they cannot get their share back because their share went to pay for somebody else.

Problems of the Provider's Behavior

Yet another problem occurs as the system changes the provider's behavior. A speaker from Canada described the health care system as being rather like veterinary medicine. The provider is no longer dealing with the patient but is dealing with the person who is paying the bill. Since the person who is paying is different from the patient, the situation is like veterinary medicine. You bring in your dog. You and the veterinarian talk about the dog. The veterinarian does something to the dog. You pay the bill. The dog really does not have a lot to say about the whole matter.

Problems of Controlling Providers and Consumers

If we create a national health care system, we discover that providers have an incentive to prescribe more in order to get more money. Consumers have an incentive to demand more. Then we have to have a system to control providers and consumers. Now we are into a further stage of problems. How can we restrict providers and consumers? We have to have someone looking over the doctor's shoulder, and we have to erect barriers to access for the consumer. National health systems usually evolve along the simplest of lines. They allocate goods and resources according to things like blocks of time. Those people who are willing to wait long enough will get treated. Since the health system is

political, the resources are directed to the area that maximizes votes.

Then we have the paradox of people on waiting lists and complaining about the national health system, on the one hand, while on the other hand are the vast majority of people who have very little contact with the system and are happy with it. Reasonably healthy people between 18 and 60 comprise the bulk of the population in any country. Most of the population will be happy and will reelect the politicians if the government generously funds basic front-end care, dental care, basic general practitioner care, emergency care, and obstetrics, and then provides this care quickly without long waiting lines. As one doctor from Canada said, the Canadian system has very simple quality control. As long as the provincial health minister's name is not in the paper, the Canadian system is providing quality care.

Certain people do get left out, such as people who have serious illnesses that are expensive to treat. Look to Great Britain for a great example. In the United States 90 percent of ambulance workers have paramedical training. In Britain that number is 10 percent. Fifty million people live in Britain, and 25 million ambulance rides occur every year — one for every two people in the country. They drive elderly patients to the pharmacy to get a prescription filled and take them back home. Imagine what they could do to treat seriously ill people if they charged for frivolous ambulance rides. The British system spends $70 million on aspirin and over-the-counter sleeping tablets and pain pills for people in the hospital. The pills are free. If the system charged the market price for such things, they would have $70 million with which they could treat a couple of thousand more cancer patients. But that is not the politically popular thing to do.

Our Current System's Perverse Incentives

The problem with our current system is that it has all the defects of national health care and none of the virtues. We encourage people to behave as if we have national health care, but we do not control their behavior. For the last 40 years we have had what amounts to a cost-plus payment system for health care. We pay the cost plus a percentage on top of that. That is how the Defense Department contracts, and note the problems it has had.

In such a context, competition is meaningless. If the Defense Department wants to buy an airplane but does not know what it wants the plane to look like or what it wants the plane to be able to do, it still asks how much it will cost to develop and produce. At that point competition between Northrup and Rockwell becomes pretty meaningless. Pretty soon everybody is playing a game of how many contracts they all can get out of the Defense Department. We have all seen the horror stories about the $600 toilet seats and what not. That is what we do in health care in this country. We do not control it. We have tried, but we have kept backing off. Why? Control becomes very onerous.

When we look at the problems in the system, we see that many of them stem from tax policy. Through employer-provided insurance we have in effect told employees that we will give them preferential tax treatment only if they buy their medical care through insurance and if they buy that insurance through their employers. Employees will be left out in the cold if they do not get their insurance in this way.

We create the same basic, perverse incentives because most people do not even realize the value of their benefits. They have an incentive at some point in the system to view it as a free good. At the same time, providers have an incentive to charge more and more because the bill is going to a third party that does not have the methods of controlling costs that a national system has. Furthermore, the system that we have is not flexible enough to meet changing needs in our society. As a result it has become increasingly unsatisfactory for everyone, including those who do have coverage.

The Tax Reform Proposal — Two Parts

How can we change our system to solve these problems? Our proposal has two parts. First, we need to restore normal market functions in health care in order to encourage innovation and efficiency. At present if we save money on our health care, we are not rewarded with more cash in our pockets through employer-provided insurance. On the other hand, if we buy a $200 television set instead of a $250 set, we keep $50 to spend on something else. If a provider tries to determine whether to buy a magnetic resonance imager (MRI), the determining factor is not whether the MRI will provide better care to the patients and attract more patients to this provider rather than to another. Instead, the determining factor is that the MRI will enable the provider to increase billings and get more money from the insurance company. We have to change these attitudes. To do so we must first restore normal market functions.

Second, we need to develop a system for subsidizing those who need care. What I am proposing is a basic framework. The details can be discussed and debated later. In fact, we have not yet worked out all the details, but the basic plan is as follows.

Features of the Basic Plan

Equalizing the Tax Treatment

The initial step is to equalize the tax treatment of health care in this country. Regardless of who one's employer is, everyone should get the same tax benefits for health care. Everyone should also get the same tax benefits whether they buy insurance or buy out-of-pocket care. The decision about whether to purchase something through insurance or purchase out-of-pocket should be based on one's own personal circumstances, not on something imposed from outside.

At that point we would start to even out the disparities among individuals within the tax code. For example, rather than a deduction that benefits upper earners more than lower earners, we would put in a flat tax credit for all health expenses. Health expenses would include both out-of-pocket medical care and health insurance. We could do some econometric models to determine what the optimum numbers are; but for the sake of argument, let's say 25 or 30 percent of one's income. That is roughly equivalent to the value of employer-provided insurance today. Everyone would get the same flat tax relief for all health care expenses regardless of what they are or what they cost. This change would be a politically popular way to move out of the present system. It has the desired effect of encouraging people to put health care higher on their priority list than buying jeans or beer or whatever.

Building Subsidies into the System

The next step is to build into the system a means to provide subsidies to those who need them the most. We could say that if one's health expenses exceed a specified percentage of income, an arbitrary figure again for the sake of argument of, say, 5 percent, then the tax relief rate goes from 30 to 40 or 45 percent. If those expenses exceed, say, 7.5 percent, the relief could go to, say, 60 percent. Again, all these numbers can be changed. The basic idea is to create a sliding scale whereby the greater one's health expenses are in relation to one's income, the more subsidy one receives.

We further build upon this step by restructuring public programs around this subsidy mechanism or by making other adjustments to the tax code. For example, at present if one does not provide the primary support (over 50 percent) for an elderly parent but does assume some of the parent's health care costs, no tax deduction is available. The new system would let that person help with the parent's long-term care cost or help with the purchase of long-term care insurance and then let the person get tax relief for those expenses. Further, the tax credit can be made refundable for people of low income. Many people at the lower end pay little or nothing in income taxes but pay a great deal in payroll taxes. The refundable tax credit comes from these payroll taxes. A family of four making $15,000 pays $2,500 in federal taxes, $250 of which goes to the IRS in the form of income tax. The rest is payroll tax. Under current policy we tax that family back into poverty. That $2,500 could go a long way toward providing health care for such a family.

When we reach this point, we have to coordinate with welfare policy. Many conservatives and liberals are pushing the idea of expanding the earned-income tax credit now so that there will be more money available to people on the lower end.

These kinds of tax changes would be funded by eliminating the tax exclusion for employer-provided insurance. Employers would be required to report how much they spent on employees' health care. Employees would then have the money in cash. They could buy what they want with it and get the tax relief in the personal income tax code. To these reforms we would then add public finance programs for the very poor and for other groups, such as the elderly or the disabled.

Benefits of the Proposed Tax Reforms

What would be the effects of these tax reforms? We would see a renewed doctor-patient relationship. We would see doctors having incentives to provide their patients with the best value, the best care for the least cost to attract or keep them. We would see doctors looking at technology in relation to what would make their delivery of health care more effective and efficient. We would see consumers having an incentive to get the best deal both on their insurance and on their out-of-pocket medical care. Some people would pay much less for their health care than they do now. They would have the cash left over. They would be taxed on it, and those taxes would go to support those who pay more, who need to pay more.

Insurers would be forced to become much more competitive than they now are. Frankly, the health insurance industry has been a gravy train for the last 40 years in this country. Insurance companies have collected the bills from the providers, repackaged them in the form of premiums, and sent them on to the employers. Only in the last 10 years have employers started to complain about insurance companies' charges. These companies would have to become more efficient and much more innovative than they are now.

Employers would not necessarily be cut out of the benefits picture. Employers could voluntarily broker to help people get the best deal. That could be a service that employers want to provide for their workers, or it could be a result of labor-management negotiations. We have a parking benefit like that at the Heritage Foundation. On a voluntary basis, my employer worked out the best deal on parking that we would be able to get from a parking lot. The foundation made parking a voluntary payroll deduction and sends one check to the parking lot. Everybody benefits. The employer keeps the employees happy. The employees are happy that they do not have to do the shopping themselves for the best parking deal, and they do not have to send a check each month. The garage benefits because it is guaranteed a certain number of slots and one check every month.

Our proposal has a requirement for heads of households and their family members to have catastrophic insurance. We are open to suggestions about how to enforce that requirement. One suggestion is to use the tax code. Another idea is to have employers serve as monitors who deduct the money and make sure that people are insured.

Ultimately the benefit of such a changed approach could be that we start to change our attitudes about health care in general. Nevertheless, even if we put the changes in place tomorrow, the attitude change would take years to achieve. It still could happen.

Consumers will begin to look at providers as those who keep them healthy, who keep them from avoiding higher expenses than necessary, whether out of pocket or insurance. Managed care could be quite competitive in this kind of environment. Right now when an employer tries to cut cost by raising the deductible or by putting employees into a managed care plan, the employees view the change negatively, resent it, and reject it. On the other hand, if we put the same dollars in the employees' hands and let them make the decisions, their attitudes will start to change. For example, the employee might choose to save $150 in premiums by raising a $100 deductible to a $200 deductible. Consider another example. If the employee has the choice of comparing the indemnity company and the managed care company and finds equivalent services for lower premiums in the managed care company, a much more positive attitude results. This changed attitude is the benefit. Consumers need to look at health care providers as people who keep them healthy as opposed to people who fix them when they are broken.

A Genuine National Health Insurance Plan

William Glaser, New School of Social Research

For 30 years I have been doing field research in other countries for extended periods of time and in a variety of fields, including government, industry, professions, migration, and health care. This experience has led to the publication of books on how doctors are paid in Europe and North America; how hospitals are paid in Europe, Canada, and the United States; federal-provincial relations in Canada, Germany, and the United States; and how health insurance works in Europe and the United States. All this work has involved spending long periods of time with administrators, scholars, executives, physicians, and hospital administrators. Using this experience, I shall describe how other developed countries organize national health insurance and the implications of their systems for the United States.

Problems in American Health Care Finance

At this forum we have heard much about the problems in financing U.S. health care. We have been hearing about these problems all our lives. They include the following:

- Access, with many persons lacking any or adequate coverage
- Inequalities in services by personal wealth and by race
- Gaps in benefits
- High costs, which are uncontrolled
- Waste of resources
- Excessive overhead and bureaucracy
- Disputes resulting in many lawsuits
- Confusion and uncertainty about benefits and reimbursements
- High-tech bias, with too many invasive tests and treatments
- Self-centered financing system, which lacks the redistribution essential for a social policy
- Microeconomic orientation of policy thinking, which results in the inability to redesign the system as a whole

Noted at the bottom of this list, one of the largest of all American problems is policy thinking. The United States is experiencing a severe crisis in how to think about reform, how to understand the existing system. For some time the United States has been in the hands of neoclassical welfare economists with somewhat utopian hopes about how competition can become the basis for a comprehensive health care financing system.

Distribution of Coverage

After listing the problems, we must note how

coverage in the United States is distributed among all the different insurance carriers. At this forum we have been describing this complicated mosaic of insurance companies, including Blue Cross/Blue Shield and others. In 1986, for example, 44.4 percent of Americans under 65 had hospital insurance, and 56.4 percent had major medical insurance. Blue Cross/Blue Shield was the principal carrier for hospital insurance and had a substantial market share of major medical insurance.

The Uninsured

The uninsured include both the people without insurance and the people on Medicaid, since Medicaid is a public welfare problem and is not insurance. America has always had a lot of uninsured people. A myth exists that the number of uninsured has grown during the 1980s. Even in 1977, supposedly the high point of American health care financing, 18.3 percent of Americans were uninsured. Although this number is smaller than the 20.8 percent who were uninsured in 1987, the number is still very large. The problem is endemic to the American system.

National Health Insurance in Other Countries

In understanding national health insurance, we have a confusion in American health policy thinking, a blind spot about the Canadian system. Americans are constantly talking about it, and this forum has witnessed much discussion of it. The Canadian model is one of the buzzwords of Washington. Canada is an important country with many valuable ideas for the United States. However, Canada has a system very different from the other developed countries.

National health insurance is what the other countries most relevant for the United States have — France, Germany, the Netherlands, Belgium, Switzerland, Denmark. Until the fixation with mandated employer-based insurance began in the mid-1970s, every bill for national health insurance in the United States would have enacted such arrangements.

National health insurance is simply a social security program. It is set up very much like social security in all these countries. Parliament passes a law. The law does not nationalize doctors and hospitals. The idea is to keep the system as close as possible to the original private model. Every one of these countries had mutual aid funds going back for centuries, and they have had mutual insurance companies for some time. The idea is not to rock the boat but to perfect it. Consequently the doctors remain self-employed, private, for-profit business people. Hospitals remain either nonprofit or municipal. The government does not take over either doctors or hospitals. The rule is that any mutual aid fund that existed before can remain as a carrier under the official program. That situation means that nonprofit mutual insurance companies can opt to stay in the health insurance market under social insurance. However, the money becomes part of social security.

Payroll taxes exist on the employee and on the employer, like those for pension programs, for work accidents, and so on. The law mandates that certain groups in the population shall be covered. They begin with industrial workers. They go on to the other blue-collar workers, white-collar workers, the self-employed, and farmers. Government requires that certain categories of the population enroll. They must sign up with a health insurance carrier, any carrier. Usually free choice remains. They had free choice before, and they have free choice now. Usually these are family programs. Spouses and children are fully covered under the breadwinner's payroll tax.

The law includes minimum benefits that the sickness funds must cover. Then we need to note ground rules. To be paid under the system, doctors must follow certain rules about billing. If hospitals want to be paid, they must follow certain procedures for determining their budgets. Nevertheless, implementation is surprisingly private.

Among the bugaboos in Washington is the fear of centralized, nationalized plans. Such fear is expressed at the highest level. Going down to the Atlanta Council on Competition in 1990, Secretary Louis Sullivan was horrified that all other countries supposedly have centralized, national plans. We in the United States cannot have that kind of insurance, he said. We must perfect the status quo. The truth is that none of these countries has centralized, national plans. They all have quite complicated plans, but they are semi-private and semi-public.

An elaborate system of negotiated cooperation is needed. Government does play important roles. It mandates payroll taxes. It mandates that certain groups must be covered. It creates ground rules for doctors and hospitals. Perhaps government also adds some cash in subsidies to the sickness funds, particularly for the elderly and the poor. Something is needed to match the elderly's own contributions since no employer contribution exists.

One of the serious problems in the United States now is the notion that Canada is the only foreign country that has a universal health system. Canada has fully public financing, and each Canadian province has a Ministry of Health that horrifies the hospitals in

particular. All the rhetoric in Washington about government centralized controls may be relevant to deciding whether the Canadian model can be adopted here. That rhetoric is very misleading because European nations, which are more relevant to the American situation, simply do not have a centralized government power in their national insurance. Why? All these countries are democracies — Germany, France, Holland. Why? The doctors would oppose it.

Dan Beauchamp said here that he is going to take on the doctors. If he does, he will fail to get anything enacted. Any country that tries to take on the doctors is going to produce such a political uproar that the parliament will retreat. The only way to have a health insurance system that covers the whole population is to have a system that will cooperate with the medical profession. That profession does not get all it wants, but it gives and takes.

The health insurance carriers remain an important set of players — the mutual assistance funds from several centuries ago and the insurance companies of recent years. Some stay in health insurance; some drop out and specialize in life, accident, or supplementary insurance. But they remain remarkably private and nonprofit as they were before. They benefit a great deal from these systems. They become larger and wealthier, and that point is important in relation to power. If they are threatened with the Canadian system, the insurance industry will fight it.

National Health Service in Other Countries

England, the Soviet Union, Poland, Italy, and Spain once had national health insurance but now have national health services. In these countries national health insurance did not succeed. Particularly if the hospital sector collapsed, government stepped in. Great Britain has had a national health service since 1948, the Soviet Union since 1917, and Italy since 1980. The government owns the hospitals, and the government has contracts with the doctors.

Doctors successfully resist being dictated to, and no national health service except that in the Soviet Union really dictates to the doctors. People in the Ministry of Health in Great Britain certainly know this reality, and they have to cut deals with their doctors.

The Canadian Model

Canada has a unique, mixed system. No other country has anything like it. As in the U.S. system, the doctors and the hospitals are private. The medical profession is completely self-employed, and most hospitals are nonprofit. Yet the Ministry of Health grants money for global budgeting to the private hospitals. The myth is that Canada has a single-payer system, but that is only true for hospitals. Provincial parliaments grant money to their Ministries of Health, who then pay hospitals and doctors. The method of dealing with the doctors is much more complicated. The doctors are paid by fee for service.

Canada certainly delivers high-quality care and does so much more economically than the United States does. Technically, Canadian care is exactly like care in the United States. They have learned to live within budgets. The whole population is covered with no limits on access. Some cooperation is developing between Canada and the United States. For example, some of Ontario's high tech cases are treated in Detroit, and some of Vancouver's patients are sent to Seattle. That is how waiting lists are cleared.

The Potential for Employer-Mandated Programs in the United States

Much discussion has been going on about employer-mandated health insurance in the United States. Laws would be passed requiring all employers to cover their workers. Some of the state programs have such laws. Marilyn Matsunaga described an employer-mandated scheme in Hawaii. Massachusetts has had one for a couple of years, but it is crashing in flames and will almost certainly be repealed in 1991. Nevertheless, the television news programs carry various discussions about employer-mandated programs as the solution to American health care.

Such programs will not be enacted in the United States because of the resistance by big business as well as small business. Policymakers in Washington have utopian beliefs. We can introduce a competitive free market, perhaps a structured market with a whole series of separate managed-care nostrums, but no real hope exists to enact one of these schemes as a national system. Even if an employer-mandated program were enacted, it would have all the defects of the present situation. As Steffie Woolhandler noted, such a program would involve a series of separate entities, including different insurance carriers with different benefits and different rules with payers. Each individual employer would be eager to minimize its own costs and have the insurance carrier spread the cost to other payers. Small business would provide tremendous resistance and would not allow any full coverage.

The Potential for a European-Style National Health Insurance in the United States

General Provisions

The United States could enact a national health insurance like that in European countries. Congress would mandate that many occupations, perhaps all occupations, shall join statutory health insurance. The law would allow all carriers to participate, including Blue Cross, Metropolitan Life, Prudential, Mutual of Omaha, and so on. So the private insurance companies would still be involved with health insurance claims.

The law would provide that any subscriber can choose any carrier. The law would also provide that the carrier cannot reject bad risks, something that some carriers can now do. The possibility exists for the law to allow private supplementary insurance for additional benefits or for patient cost-sharing.

Provisions for the Elderly, the Poor, and the Disabled

The elderly would stay with the health insurance carriers with whom they have spent their lives. Medicare would therefore not exist. This change would eliminate the large numbers of jobs in Washington and Baltimore held by people who have a vested interest in managing Medicare. The management of health care financing would suddenly go to the health insurance carriers, such as Blue Cross, Prudential, and so on. The Health Care Financing System (HCFA) and the Medicare system would no longer be needed.

The poor and the disabled would also be able to pick their sickness funds. Medicaid would not be needed. Every country with national health insurance once had welfare medicine, but gradually the poor and the disabled have all been folded into mainstream health insurance. Of course, the poor and the disabled do not bring in their actuarial premiums. That fact is one reason for public subsidies. But we know that we already have subsidies, mainly the federal and state money for Medicaid. These subsidies would simply go to the carriers, and the poor and the disabled could select their carriers.

The Necessity of Payroll Taxes

The methods of revenue — Social Security and payroll taxes on workers and employers — would exist just as they do for pensions. But the American people would get a shock. A lot of people in this country live in a fool's paradise because they think that they are getting health insurance free from their employer. In the late 1980s the bad news began to emerge with contributory schemes. Employers are expecting employees to contribute toward the premiums for themselves and their families. However, these contributory payments are still much less than full-scale payroll taxes in health insurance.

Every one of the countries with national health insurance requires a considerable percentage of the worker's own income to be used for health insurance accounts, even as high as 6 percent in Germany and 7 percent in France. Under the budget negotiations in Washington, earning ceilings for Medicare will now be raised. But some countries have eliminated the earning ceiling completely in order to bring in enough money for health insurance. That kind of action would force Americans to face the fact that an expensive health insurance system requires full payroll tax payments by every person.

The elderly also pay a percentage of their pensions abroad. A lot of the American elderly now are accustomed to paying virtually no premium, although that amount will be going up to $35 a month. That amount is minimal compared with what the elderly are paying in other countries. The elderly are now getting a free ride from the payroll taxes of 1.45 percent on workers and employers. With national health insurance the elderly would have to pay a larger percentage of their pensions, supplemented by public subsidies.

The scheme is that the revenue would go into the sickness fund that the individual has chosen. A computerized management system would direct one's earmarked payroll taxes and the employer's payroll taxes into one's own sickness fund. Then, as noted previously, public subsidies for the poor and the elderly would be added. Of course, large public subsidies for Medicare Part B already exist. Washington is currently fighting to control Part B costs because they come out of the U.S. Treasury.

Low Government Scrutiny

Financial management by the carriers would be much like Medicare fiscal intermediaries today. Surprisingly, much less government scrutiny of the accounts would be required. The sickness fund might be required to present an annual account to some public regulator, often an independent corporation, but the requirement would not be the detailed intrusion that presently exists from Medicare to all the fiscal intermediaries. The Federal Register annually publishes over 220 pages of regulations from HCFA to the fiscal intermediaries. No

other country has that kind of documentation being published every single year.

Cost Guidelines

Cost guidelines would exist. One major advantage would be that cost containment from this organized system would exist, but it would not be dictated. Americans have the notion that government will dictate the costs. The system would not work this way. The sickness funds themselves would be the first line on costs since they would have to live within the premiums and the payroll taxes. Nevertheless, government would be concerned that payroll taxes not go too high, and government would provide subsidies. All this would involve an elaborate negotiating system to settle cost guidelines — involving the various ministries of the government, business and labor interest groups, the medical associations, and the hospital associations.

All-Payer Systems

All-payer systems have to exist for the providers. Doctors will not allow government to dictate, but doctors are not allowed to bill whatever they want, and the sickness funds do not pay different rates to doctors. Collective negotiations then occur between the medical associations and the health insurance carriers through which fee schedules and standard fees result.

With some variation from country to country, an all-payer system also exists in the hospital sector. It is an all-payer system with many payers, so that some collective decisionmaking occurs. For example, each hospital's rates may be regulated by civil servants, or the individual hospital and the sickness funds in that area negotiate over that hospital's unique rates. Nothing like diagnosis-related groups (DRGs) exists. Each hospital gets a budget appropriate to its needs.

Cost Sharing

A number of options emerge for patient cost sharing. Every country varies in these options. Some of these options concern how much is put in the mainstream for social insurance, how much is allowed for private insurers to offer, and whether all groups are covered. Germany leaves out the elite, who then go into the private market.

The Need for Renewed Knowledge About European Systems

Before World War II Americans knew much about what was happening in health insurance in Europe and participated in a worldwide exchange of policy advice. Since World War II Americans have lost contact with European social security, social insurance, and health insurance. This present fixation on Canada is actually a mental blinder. What is extremely important is that key groups, such as the NEA, really begin to ask how other countries provide and manage health care and then take a position on the issue.

Health Care Reform: The Buy Right Strategy

Walter McClure, Chairman, Center for Policy Studies

I would like to share with you a two-part strategy for health care reform, called Buy Right. The first part is a local strategy for purchasers of health care benefits to contain their cost. The second is an entirely new approach to national health insurance, combining universal coverage with spreading the local strategy nationwide. I shall focus mainly on the local strategy.

Problems of the U.S. Medical Care System

The problem of high-cost health insurance is not an insurance problem. It is a medical care problem. In particular, it is a medical care system productivity problem. Only 5 percent of one's premium is insurance expense, and that is not the escalating part. The other 95 percent is medical expense, and that is what is out of control. Thus, if we want to control our insurance cost, we must address the medical care system and its productivity.

We know from international research that a country's health care coverage dictates the shape and the performance of that country's care delivery system. If we want a cost-contained, high quality system, we have to decide first what kind of health care system will do that for us and how we are going to leverage the present system. Then we need to design our coverage to foster and fit that design. In other words, when designing strategy, do system reform strategy first, coverage design second. That point is valid for purchasers and countries alike. Unfortunately, most countries proceed backward: coverage design first, system reform later. The United States seems ready to make the same costly mistake. We design our coverage system to fit the health care system in place at the time. The result is that the system is locked in, regardless of its strengths and weaknesses.

The last thing the United States should do is to lock in its present medical care system. Let's put this point in perspective. Our health care system is helping millions of people every day. I myself am one of those beneficiaries. My son, who was born with a cleft palate, is one of those beneficiaries. Because of the caring and skill of a number of doctors, my son can eat and speak reasonably normally today. So to abuse our physicians and hospitals, I think, is a mistake. On the other hand, of all the industrial countries' health care systems, ours has the poorest macroperformance. Other countries achieve equal or better health results for only 7 to 9 percent of GNP (gross national product), and they cover all people. Ours costs 12 percent of GNP, yet 15 percent of our people remain uncovered. Consequently, people are getting hurt who do not need to be.

The most serious problem is cost. First, cost is the only thing stopping universal coverage. If we stopped the cost rise, we would have universal coverage the next day. Second, the cost of health benefits is now visibly eating into wages and other benefits. In addition, in the public

sector the cost of Medicare and Medicaid benefits is eating voraciously into all other public services, including education. So teachers are catching this problem from both ends. Third and perhaps most serious, health care cost now threatens our national well-being. The goose that lays the golden eggs for all our private and public purposes in this country — jobs, income, public programs — is the competitiveness of American goods and services. We are falling behind, not only in foreign markets but in our own. With other countries spending only 7 to 9 percent of their GNP on health care while the United States spends 12 percent, every American good and service goes to market with an added 3 to 5 percent premium on its price to pay for redundant health care. Health care cost has become a serious detriment to American competitiveness.

Not only for health and coverage but also for our national economic well-being, we must reduce the share of GNP devoted to health care. We must make this adjustment without hurting quality. Ultimately we have to do so while extending coverage to the uninsured. The national health care goal is to extend superior care and coverage to all Americans at costs each can afford, while shrinking health care as a percent of GNP — a tall order.

Alternative Strategies for Cost Containment

What are the options for cost control? Only two options exist. One is to spend less by accepting less —cut benefits, quality, access, and eligibility benefits. In Medicaid we have done all these things. The 70 percent of the poor that are eligible has been reduced to 40 percent. That is called cost containment. What was the point of the program? Similar cutbacks are now rampant among private purchasers. The other approach is to get more for less — a productivity increase. In fact, since we wish to improve quality while extending coverage to all Americans yet shrink cost as a percentage of GNP, the national goal is impossible without significant and continuing productivity increase.

This point holds equally for all local purchasers. If we seriously want to contain cost for beneficiaries without cutbacks in quality, eligibility, or benefits, we must use our purchasing leverage to change the productivity of the health care system in our various locations. We must have a health care productivity strategy.

Health Care Productivity

We can have a good idea of the pay-off from a productivity strategy simply by comparing the productivity of all providers with the productivity of the most efficient high-quality providers in the system. Productivity and efficiency vary enormously among providers today, at least twofold from one provider to the next. What few people realize is that quality also varies enormously from one provider to the next. For example, in most large metropolitan areas a person is 50 percent more likely to die in the worst hospital than in the best! (And that comparison is made after adjusting for severity of illness.) Moreover, the quality of providers varies independent of their cost. A wealth of studies establishes these points. Let us look at average annual cost per resident elder under Medicare in different cities. The highest cost city is Miami, which is 66 percent higher than the national average, per elder per year. The lowest cost city is Rochester, New York, which is 29 percent lower than the national average. That is more than a twofold spread in the cost of reasonably comparable patients! Los Angeles is 40 percent above the national average; Boston is 20 percent above the average, and so on. On the other hand, Rochester, Minnesota, and Seattle, Washington, are 20 percent below the national average.

Providers say that these differences are due to sicker patients and higher quality. How can we say that elders in Miami are sicker than elders in Boston or Seattle? How can we say that quality in Miami is better than quality in Boston or in Rochester, Minnesota, where the majority of resident care occurs at Mayo Clinic? All this is nonsense. If further patient adjustments change these numbers by 10 percent either way, I would be surprised. These are real differences in provider efficiency, and they are huge. The closer we look, with adjustments for patient comparability, the more these differences hold up, not only across cities but also from provider to provider within the same city.

The point is that if all providers were as efficient and high-quality as the most efficient providers today, not only could we reduce cost by 20 to 30 percent without inventing anything new, but quality would also go up. This point is not just 20 or 30 percent fewer dollars; it is 20 to 30 percent fewer doctors and hospitals to get superior results! Such a reduction would be more than enough to cover all the uninsured while returning handsome savings to consumers, purchasers, and the government. This amount of savings also does not have to be one time only. Other fields show steady productivity increases over time, year after year. No reason prevents the health care system from joining these other fields, but we must change the system to do so.

Competition and Markets

The most powerful device for productivity ever

invented is Adam Smith's sound market. Nothing else even comes close. This truth has now been proven theoretically and empirically; it is no longer ideological. Even the Soviets now know that Karl was wrong and Adam was right.

How could sound markets be brought to bear on health care? First, let's make sure that we know what they are. Some 200 years after Adam Smith, much ignorance and confusion about markets exist on both the liberal and the conservative sides — some of it seemingly intentional. The term "competition" is freely bandied about without distinction as to whether it occurs in sound or unsound markets. Experts know that competition in unsound markets disserves the public interest, whereas competition in sound markets is the most powerful device ever invented to make producers serve consumer interests. I keep trying to convince my liberal friends that sound markets are a really radical idea.

What is a sound market? Notice that Adam Smith did not advocate getting government out of the market so that all will be well. He did say that the invisible hand will lead competition in the public interest only if certain conditions are present in the structure of a market. If these conditions are not present in a market, that market is unsound, and the unseen hand will lead competition against the public interest. These conditions do not occur naturally in most markets. In other words, laissez-faire and sound markets form an oxymoron: most natural markets are unsound, and most sound markets are artificial. The conditions for soundness must be deliberately imposed and maintained by public policy. If government does its job well, the market stays sound and serves the public well. If government does not, then the market conditions go astray. Like a football game without sound rules or referees, it becomes a brawl, and the cheaters win. For example, we merely deregulated airlines; we did not establish sound market conditions; consequently, the airlines monopolized at the hub cities. Where was the anti-trust department when we needed it?

The Health Care Market

Health care is a particularly unsound market. In its present shape it violates the required conditions. (For historical reasons now outdated, those conditions were never imposed.) While competition is vigorous, even vicious, the market is unsound. Competition in health care is cost-raising, i.e., against the public interest and not cost-saving and quality-raising as the public wants and needs. The liberals cry that competition in health care has failed. The failure of competition in an unsound market is hardly news. Even Adam Smith knew that. The conservatives cry, let the market work. Letting an unsound market work makes sense only for self-interest groups enriching themselves on the unsound market at the expense of the public.

Health care competition is malperforming exactly in the way its present market structure dictates. The present unsound market stringently rewards providers for cost-raising behavior, independent of health results. If they are not sufficiently cost raising, they go broke! Why should we be surprised, therefore, that providers keep raising costs independent of results? The fascinating point is that the providers cannot act otherwise. They are trapped. They are powerless to change the unsound market structure and its perverse rewards. The next equally fascinating point is that purchasers, and only purchasers, can do the rewards, because we pay them! We are up first. If we change the way we buy and start buying right, then providers will be compelled to perform well.

To make a sound market in which we buy right, purchasers merely have to insert Adam Smith's conditions into health care:

- a variety of competing producers, sufficient in numbers that they must be price takers rather than price setters
- freedom of entry of new producers into the field
- no collusion among producers
- informed consumer choice, requiring consumers to know the quality and total price of the product offered by different producers
- value-rewarded consumers, individually rewarded for judging value as well as quality in their choice of products and producers
- proper government market regulation, enforcing antitrust laws, consumer protection laws, and truth in advertising

Instead of treating these conditions as some ivory tower wisdom that we overlooked in Economics 101, we must start regarding them as the engineering specifications for an effective productivity-based cost containment strategy.

Fallacies of Price Controls

Before suggesting how purchasers can use these conditions to make health care a sound market, let's consider the other major alternative to contain cost. Under all the variant proposals, only two major ways exist to deal with an unsound market. Either we succeed

in achieving a sound market with proper government market oversight, or we impose economic controls (government price, use, and/or franchise controls) on the market. Many people seem enamored of price controls on health care. Even some major business firms have come out in favor of them. Perhaps the best way to summarize the performance of government economic controls is to say that even the Soviets now know that imposing these controls is a stupid way to do things.

What is the problem with economic controls? They seem so simple in principle and in implementation. The answer is that, both theoretically and empirically, controls have been shown to produce extremely poor performance relative to sound markets. Consider West vs. East Germany, South vs. North Korea, Singapore vs. Cuba, and so on. Controls should be considered a last resort, only for public utilities and other natural monopolies where sound markets are not possible. My view is that price controls are the last thing we would want to impose on one-eighth of the U.S. economy — health care.

Empirically, price controls exhibit a predictable course. They begin with a honeymoon period of 5 to 15 years in which things seem to be working satisfactorily. This impression is why they are so politically seductive, essentially while they coast on any strengths of their private origins. Then certain predictable problems begin to emerge, which worsen the longer the controls persist. Quality erodes. Productivity erodes. Innovation erodes. Responsiveness to consumers erodes. Undercapitalization grows. Rationing grows. And waiting in line grows. I do not know of a single exception to this reality, in any industry or any country that has imposed economic controls on a system.

These problems are intrinsic; we cannot escape them by trying harder. If government intelligence, motivation, or effort could correct them, the Russians would surely not now be trying to turn to sound markets. The most severe fallacy about controls is the assumption that one can predict "correct prices." Correct prices by definition are those that maximize productivity and consumer well-being. They have nothing to do with fairness or producer cost. They are simply signals to consumers and producers about where to buy and what to make. Economists can prove that correct prices arise only in sound markets. They arise empirically from interchanges between willing buyers and sellers, and change dynamically with unforeseeable changes in supply or demand. They can be measured at any time but are impossible to predict in advance.

So the government has no way to predict correct prices. It must simply make a best guess, and its best guess is unlikely to escape politics. Powerful producer interests will attempt to influence prices, usually to reflect current producer costs. For example, Medicare is now using price controls, and the American Medical Association and American Hospital Association have convinced Congress to adopt price schedules reflecting provider costs. (Remember that correct prices have nothing to do with producer cost.) Altering price schedules becomes politically more difficult once consensus on the initial schedule has been reached. For example, British health care observers report that this year's prices are generally last year's prices plus an allowance for inflation plus an allowance for scandals. So the required dynamic character of prices is lost.

Let's observe how price controls work in health care. Because no way exists to predict correct prices, the government will guess too high on some, too low on others. Some services will be winners and others will be losers in terms of how profitable they are for providers. Since the government can only contain cost by constantly squeezing down on prices, usually by freezing them, many losers become real losers. Not even the most efficient provider can produce them without losing money. Conscientious providers will provide the services that patients need, even if some services are losers. But they will have to pump in some extra winners in order to make up for the loser services. Even conscientious providers begin to distort their practices to make ends meet, and productivity falls.

Less conscientious providers will simply avoid loser services and pump winners. They will ignore needed loser services or refer such patients elsewhere. Then quality, access, and responsiveness to consumers falls, and the entire system begins to be distorted and run on manipulating the controls. Europe is full of health care systems that are distorted by these artificialities of price controls, each in its own way. Even in cases in which governments have contained overall cost, the success of which varies from country to country, they still cannot avoid these distortions of artificial prices on quality and productivity. And these artificialities of the pricing and, therefore, the distortion of medical practice only worsen with time. As the Soviets and other price-controlled economies now attest, price controls are a less-for-less strategy, compared with sound markets.

No escape exists from these intrinsic problems of price controls other than *perestroika* — converting the system to a sound market. But because of the seeming simplicity of price controls and the honeymoon period, countries are constantly tempted to try them. The politicians who enact them retire in glory to a grateful public during the honeymoon period and leave to their

children and grandchildren the problem of *perestroika*. I think we have left our children enough problems. The time for *perestroika* in health care is now. I see only one virtue of government controls: they would be better than our present unsound health care market. Both Europe and Canada are better off than the United States because at least everybody is covered. Why settle for a second-rate strategy at which the United States is sure to be second best, since we are so much larger and less homogeneous than these countries. Why not leapfrog our foreign competitors entirely by trying for a sound market. If we succeed, they will have to chase us. If we cannot make it happen, we can always resort to price controls. But if we go to controls first, we will spend the next 50 years trying to make them work before we can even raise the question of sound markets again.

Summarizing the Problem and the Solutions

Let's summarize where we have come. We do not have an insurance problem. We have a health care productivity problem. Therefore, we must have a productivity strategy. Sound markets have the best record in the world, and government price control systems have a very poor record; so let's try for a sound market.

Insurance per se is not a sound market strategy, although insurance companies try to argue that it is. Insurance only distributes the bill for the health care system. The health care system determines the cost, not how the bill is spread. Simply changing insurers or going to a larger insurance plan does nothing to control the cost of the health care system. Such a move does not change the system or its productivity.

Some people think that managed care plans driving discounts and policing unnecessary services are a market strategy. I think that strategy is merely useful in the short term to trim some obvious fat. The savings are limited and one time; the discounts and policing methods have to be refought each year just to keep the same savings. The managed care plans of today in no way establish Adam Smith's conditions. Consequently, they do not produce a sound market. They are more like a private approach to price and use controls than a sound market.

A promising strategy does exist for purchasers to make health care a sound market — Buy Right. It is not just theoretical. A large group of purchasers in Cleveland — well-known companies nationally — are now engaged in the Buy Right approach. Since they have been working with it for only a year and a half, enough time has not elapsed to judge success. Nevertheless, they now think and I think that it is highly likely to work. The good news is that to change the system, we do not have to change the nation. We do not even have to change our state. We only have to change our town. The bad news is that one purchaser cannot do it alone — not a teacher group, not even a giant corporation. All the purchasers of health care in a town have to get together and change the way they buy.

Designing and Building Large Systems

To understand Buy Right, we need to look back to the point about how the system traps providers into cost-raising behavior. I shall refer to a couple of larger ideas that are useful. Health care is hardly the only large system in this country with serious problems. We have problems in many of our large systems — certain business sectors, the criminal justice system, our almost nonexistent child development system, and our public education system. Why do these large systems of organizations and individuals — macrosystems — perform the way they do? Why does the health care or the education system perform in the way it does? If a society does not like the way a macrosystem is performing, what must it do to have that system, or more specifically the organizations within it, perform the way the society wants?

To answer these questions, the Center for Policy Studies has developed a rather elegant theory called Large System Architecture. The results and the practical strategies derived from the theory of Large System Architecture have proven exceedingly useful. One startling result in many macrosystems is that the long-term performance of organizations depends little on their "innards" — the internal variables, such as the officers, the staff, their intentions, the organizational chart, and so forth. Rather, it depends mainly on their "outards" —the structure of the macrosystem they inhabit. We can see this point from three fundamental observations about macrosystems, the startling postulates of the theory:

1. An organization, like a natural organism, resides in a larger environment, the macrosystem, which it cannot alter by its own actions alone.
2. The structure of the macrosystem entrenches powerful rewards, penalties, and constraints on the organizations within it. Therefore, like natural organisms, an organization must either adapt or perish.
3. Macrosystems can be intentionally restructured by collective social action — concerted private effort, public policy, or both. One organization cannot change a system, but enough of them acting together can.

Another observation is particularly important. Think of a macrosystem as placing an allowed "window of performance" around each organization within it. If the organization can fit through this window, it will survive and even prosper. If it cannot, the macrosystem will drive it extinct. The more stringent the macrosystem — meaning the narrower this allowed window — the more the allowed performance has already been preselected by the macrosystem structure, not by the internal variables of the organization. The internal variables determine only whether the organization can adapt or perish. And in adapting, organizations will change all their internal variables any way they have to, including replacing leaders, changing intentions, redrawing the organizational chart, etc. Those that cannot will not be around for long. For purchaser strategy this window means that we do not change the performance of organizations more than temporarily by policing their internal variables. If we change their innards, they adapt right back to the macrosystem or go broke. We change their performance by changing their outward macrosystem structure. They change their performance themselves.

Let's illustrate this point with a couple of good macrosystems, both intentionally designed about 200 years ago. The first is our constitutional, federal government. Our forefathers divided the government into three branches. From the perspective of Large System Architecture, they embedded each branch in a larger environment comprised of the other two branches, the states, and the electorate. When a branch does the right thing, this environment tends to support it. When it does the wrong thing, the other branches and the electorate impede it. If necessary, they kill it. For example, the Nixon presidency had many intelligent policies, such as rapprochement with China and certain domestic moves. These got support from Congress, the courts, and the electorate. But when the Nixon administration began using secret police in the White House to assure its political success, such action was tyranny, and tyranny cannot be tolerated. When it would not stop, the other branches rose up and drove the Nixon presidency out. Our lovely constitutional macrosystem structure selected for desired performance, exactly the way it was designed to do some 200 years earlier.

A second example, much more to our interest here, is Adam Smith's market. Note that Smith did not tamper with producer organizations themselves; instead, he designed a macrostructure for a commercial market. He and his economist successors devised the structural conditions necessary for the market to select stringently for producer performance in the public interest. Sound markets do not reduce one to simple selfishness; we see far too much altruistic behavior to accept such nonsense. Instead, sound markets are realistic about people; some are altruistic and some are not. In a sound market the right people do the right things for the right reasons —they wish to serve — and revenues and business increase to further their good performance. The wrong people do the right things for the wrong reasons, because that is the only way to get rich. The sound market does not depend on their intentions or any other internal variables. Right or wrong, they all do the right thing or they go broke.

The secret is not sound markets or constitutional branches, each an excellent design for its own purposes. The secret is good macrosystem design. A good macrosystem is one that stringently selects for desired performance, i.e., the performance we as a society want from that macrosystem. It then extinguishes undesired performance. A poor macrosystem is one with a large, sloppy window of performance that tolerates both desired and undesired behavior, or, worse, stringently selects for the wrong behavior. The present health care system is one of these.

Organizations can thus perform badly for three reasons: bad people, a bad organization, or a bad macrosystem. Public attention and policy almost always overlook the third, and focus on blaming or policing the people and the organizations. How often have you heard about greedy doctors and hospitals, or poor teachers and schools for that matter, as an explanation for our health care or education problems? Here is a tip: when we see everyone doing the wrong thing, they cannot all be incompetent or immoral. Don't suspect bad people or organizations; suspect a bad macrosystem. Suspect that underneath the surface the macrosystem has powerful incentives rewarding organizations for the bad performance we observe and punishing them for the desired performance we do not observe.

We cannot fix a bad macrosystem by beating up on its people or its organizations. The only way to fix it is to change it to reward the performance we want. Think of macrosystems as complex machines that produce organizational performance. If we do not like that performance, we have to change the machine. Like Smith and our forefathers, we have to specify the performance we want and then design the macrosystem specifically to select stringently for that performance, much as we would design any other complex machine, such as a plane, a skyscraper, or a computer, to meet desired performance specifications. In other words, like any complex machine, good macrosystems must be designed and built. We have to design them as a whole, with all the parts

designed to fit together. This requirement does not do away with politics. But it is like a moon shot; at some point the politicians have to bring in the engineers if they want to succeed. We cannot cobble up one part here, another there, and leave out some third part somewhere else and hope that what is left fits together. Imagine trying to build an airplane that way. But that is how we cobble up health care systems and education systems in legislatures now. No wonder they do not work well. Perhaps these ideas can help us as we try to improve education.

What Purchasers Must Change

Sound markets are a proven macrosystem design. They select stringently for quality and productivity, exactly what we want. Nothing else comes close. Let's borrow this design for health care. Of course, we will have to modify the design a bit to assure that low-income consumers are adequately subsidized to buy care and coverage in the new market. Doing so is easy once we establish the basic, sound market. We have a great, sound food market. Few other countries feed so many so well. So we help the poor with food stamps, not with price controls on the food system. Buy Right does something similar.

To apply a sound market to health care, we simply go back to Adam Smith's conditions. We are pretty good on the producer side of the conditions. Various providers and health plans exist. A big provider surplus exists; entry is not a problem. And government has begun to use anti-trust to discourage collusion on prices. On the consumer side, however, the conditions fail badly. Consumers have not the foggiest idea what they are getting or its quality, and they are given only the vaguest idea of its real cost. They are given little incentive or means to choose providers on cost and no way to choose better providers for less. That is the ridiculousness of cost-sharing today. We cannot choose better, cheaper providers; we can only forgo care. I shall show you this condition sends providers utterly false signals about what to produce, with no choice but to produce it. Then I shall show how we can change the condition of our own towns by buying right.

Redefining the Health Care Product

To inform consumers correctly, we have to identify the product they desire of health care. It is not services. It is health results and patient satisfaction. We want two things:

1. Improvement in our health status — preventing the preventable, curing the curable, and ameliorating the ameliorable, i.e., reducing pain and disability when we cannot prevent or cure
2. Caring treatment — humane, prompt, and responsive, in dignified conditions

We do not want more services for less. We do want more health and patient satisfaction for less. Services are an input, a cost, not an output. The more services a provider uses to produce a given health result, the more costly and less productive that provider is.

I emphasize that a provider's costliness is not just prices, the charge for a given service. A provider can increase revenues not just by increasing prices but by increasing the quantity and the mix of services rendered to each patient. Medical judgment on what services are necessary is so broad, particularly for new services, that one is unlikely to stop the provider on such grounds. Indeed, the provider can give us a 10 percent discount on prices and then increase quantity and mix by 50 percent; 10 percent off 150 percent, what a deal! Such is the weakness of discounts. Thus, a provider's total cost to produce whatever health results and patient satisfaction received for a set of patients is the price times quantity times mix (expensive or cheap) of total services used.

Unfortunately, we cannot merely compare health results and total cost when we compare providers on quality and cost. Doing so ignores that patients come in all sizes and conditions. To compare providers fairly, we must adjust their health results, patient satisfaction, and cost for the severity of their patients' conditions when they enter treatment. Otherwise, providers with the sickest patients will falsely appear to have the worst results. We must define the following:

- *Quality* — The better a provider's health results and patient satisfaction compared with other providers serving comparable patients, the higher the quality.
- *Efficiency* — The lower the cost (including price, quantity, and mix) to get those results compared with other providers serving comparable patients, the higher the efficiency.
- *Costliness* — The higher the cost compared with other providers serving comparable patients, ignoring whether the results are good or bad, the more costly the provider.
- *Innovation* — The more the provider keeps raising results and satisfaction while lowering costliness, the more innovative and productive that provider is.

Show me one place where anybody provides consumers this kind of information. Indeed, show me one place where anybody — purchaser or provider — even measures this kind of information. Purchasers and providers have all kinds of information on service prices and on cost per patient. But because they do not measure comparability of patients, they have no idea whether high cost means high providers' costliness or simply sicker patients. Because they do not measure results, neither consumers nor purchasers nor providers know what they are getting for their money. If we do not measure the product, its quality, and its costliness, we cannot correctly inform consumers or provide them incentives. Thus we have a negative on two of Mr. Smith's indispensable conditions. This condition must be changed in order to get a sound market.

The Cause of Rising Health Care Cost and Inefficiency

Since we do not buy health care for the product, what do we do? We buy services — inputs — instead. We pay providers for services independent of results. We thus send providers a false signal. Not surprisingly, what we get back is services, services, services, independent of results. We get what we pay for.

Remember, as I noted earlier, that the present system traps providers into costly behavior. We can now see how that works. Superb providers and plans do exist out there; they give superb results at half the costliness of other providers. These high quality, efficient providers produce their excellent results with fewer and less costly services per patient. What then happens to their income per patient? It falls. Providers can only improve their income if they get more patients. How many additional patients does a purchaser encourage to seek out these providers as a reward for their pains? Do purchasers even know who these providers are? Conversely, other providers — some good, some not — are twice as costly as other providers. Some even look cheap on a cost-per-patient basis simply because they treat less sick patients. These costly providers use far more services, costly services, on each patient. How many patients do purchasers steer away from them as a penalty? Do purchasers even know who they are? Don't feel bad. Nobody knows, not even the providers.

Because nobody measures the product, patients do not know whom to choose. No provider gains or loses patients in relation to effectiveness of health results or costliness, but only in relation to patient satisfaction. Thus, provider income depends basically on the costliness per patient and attracting costly patients. And the costly provider can add more amenities for these patients. Remember the description of how a high quality, efficient hospital would get better results with 20 to 30 percent fewer doctors and hospitals. Turn that around; the present system now has at least 20 to 30 percent more providers than its patients need. The only way a provider can survive in such a glut is to do more on each patient. Suppose they all conscientiously became as efficient as the best. Then 20 to 30 percent of them would be out of business! Who would go over the edge first? The most efficient. In other words, we reward the costly providers for being more costly, and we punish the efficient providers for being more efficient. The system stringently selects for costly providers, independent of results.

Looking for the Fat

Let's look at some examples of the power of these terrible incentives. Doing so will sharpen our ideas for purchaser strategy. A friend of mine in Phoenix who runs a managed care plan had a radical idea. He decided to look at the most expensive patients in the plan to see if possibilities existed for reducing cost. He had to do so manually, because insurers typically cannot link claims to patients across providers. One typical example was a patient who had seen 15 different doctors, had 3 hospital admissions for heart disease, depression, and ulcers, and was prescribed some 30 medications. My friend then had another radical idea. He went to see the patient. What he found was an alcoholic. The patient had missed a lot of work, and his employer reported that the employee was not always effective on the job. In reality all these work and medical problems were secondary to alcoholism. Nevertheless, not one claim had a diagnosis of alcoholism, and no treatment addressed it. Thousands of dollars were being spent on "necessary and appropriate" health care, which the patient surely needed and continued to need since no one was getting to the bottom of his problem. But each specialist had responsibility only for his part of the problem. No one was responsible for the patient as a whole; consequently, his medical problems continued. Such is poor productivity.

A second example shows that inefficiency and ineffectiveness are not just limited to expensive cases. A study was made of 150 emergency room patients who had all received a full series of stomach x-rays. In other words, a physician was concerned enough about their symptoms to order these x-rays. The study followed up these patients to see what happened. Only 55 percent of these patients received sufficient additional work-ups for a diagnosis of whether or not they were really ill. Only

half of these, 27 percent of the sample, received therapy that could be judged medically adequate. And only half of this number, 14 percent of the sample, actually experienced improvement. Most of the slippage was not in what the system did, but in what it did not do. It had no way to guide patients adequately through the system. They were left on their own and fell through the cracks right and left — through ignorance, miscommunication, delays in reappointments, and so on. Again, thousands of dollars, many services, yet meager health outcomes.

Let's look at a final example. The United States does more intensive newborn care than any other nation in the world, and we are first on newborn survival. But we are fifteenth or twentieth on infant survival to one year. Aggressive prenatal care, which is quite inexpensive, can reduce the number of cesareans and intensive newborn care episodes, which are quite expensive, by 20 percent in a middle class population and by up to 50 percent in a high-risk population of mothers. Not only are greater savings involved, but also healthier newborns who do not need the expensive newborn care, a dramatic health improvement for less cost. The savings would pay for the prenatal care and follow-up of high-risk newborns, and ample savings would be left over. However, since we pay richly for intensive services and poorly for prenatal services, any intensive newborn unit that does prenatal care would rapidly hurt its revenues. Most of our intensive newborn care is excellent. Most intensive newborn care episodes are necessary and appropriate if prenatal care has been inadequate. Nevertheless, at least 20 percent of these cases could have been avoided if we did aggressive prenatal care. Still, providers cannot afford to do so.

Intensive newborn care involves very high technology. How often have we heard the bromide that cost is rising because of high-cost medical technology? Don't buy it. In sound markets — food, cars, computers, electronics — high technology is raising quality and lowering cost. Only in medicine does it raise cost and lower productivity. Of course, because the unsound market stringently rewards costliness, providers deploy high technology in the costliest ways. Install a sound market and they will deploy high technology and everything else for quality and economy just like other sound markets.

Managed Care — Old Style

In these and countless other examples, we see a health care system geared to the production of services and more services, but not to health results. Hence, costs are far higher than they need to be, and effectiveness of results, or quality, is much lower than it should be. The point for purchaser strategy is to try to contain cost and improve quality. Securing discounts and policing all these services alone will not work, particularly when we do not know the results adjusted for comparable patients. In the examples, the failures on both cost and effectiveness were not really due to unnecessary, inappropriate, or incompetent services. Rather, they were failures (1) to prioritize services for each patient, especially through active case-finding and follow-up, and (2) to link them together to get the best result in the most economical way. Since even the best providers strongly disagree among themselves on what the best way is, let alone on what the most economical way is, how can lay outsiders police them to do the best and the most economical way?

Policing prices and services, whether by purchasers or by government, is ultimately like trying to negotiate the cost of a car by throwing all the parts on a table and arguing the price and the appropriateness of each part. Eventually we will run out of nonessentials. Then what will we do, throw out the essentials? We can make a car cheaper by cutting off the rear end. The car won't work, but it will be cheaper. If we simply cheapen each part, eventually each part breaks. Further, how can we decide the appropriateness of any part when one part depends on the others? And how are laymen successfully going to argue the virtues of most parts with expert engineers. We are ignoring the true source of productivity: redesigning the car. The number of parts in a car and their cost to manufacture, not to mention the quality of the car, are determined by the design of the car and the production process. In a similar way, steady gain in health care quality and productivity will come only from constantly redesigning the care process and its organization. Only providers can do that, and to do it well, they will really have to want to do so.

Most managed care today is not managed care at all; it is policed care. Most managed care plans simply exist as a civil war between providers and managers. Why? They still reimburse providers for costliness, not for results and efficiency. Then they try to police down the cost when the providers respond as they must. No wonder they are at war.

Managed Care — Buy Right Style

Suppose purchasers and patients were to reward providers entirely differently. Instead of buying for services and their prices, suppose we bought for the product — results and satisfaction — and its total cost (price, quantity, and mix) as measured on comparable patients. Suppose we did so by giving patients informa-

tion and incentives so that providers and plans would lose patients to other providers and plans who got better results and patient satisfaction with fewer, less costly services. What would happen? I predict the same rise of quality and productivity as in other sound markets.

Consider the car industry. We buy a car by the car, not by a pile of unknown parts that may or may not add up to be a car. We judge the quality of a car by the car, not the supposed necessity and appropriateness of the parts as claimed by the manufacturer. We judge the car on the performance dimensions important to us as consumers, not the dimensions the car makers think important. We judge its cost by the price of the car, not the price of the parts. And we judge its value by comparing its performance and price with those of other cars available, and not by comparing the cost of two piles of parts of unknown performance. Any maker that tried to stuff extra parts into the car while discounting the prices of parts would simply push up the price of the car for all to see. Along came the Japanese in the late 1970s with measurably superior cars for the money. What happened? To compete, Detroit has had to reinvent its product, its production processes, and its companies from top to bottom. And Detroit is still at the task. It is not doing so out of the goodness of its heart for us consumers, nor out of professional pride in quality or economy. It is doing so because it will go broke if it does not succeed. Such is the selection power of a good, stringent macrosystem design — the sound market — in action.

I claim that if purchasers will buy right in health care, the same things will happen. We will get provider reform, just as we are getting car reform. By provider reform I mean that providers and plans will reinvent their product and change it from costliness to better results for less. They will constantly reinvent the health care production process. They will find better and better ways to deploy and link services to get better results for less. They will constantly reinvent how they are organized to manage better and support the new production process. And they will do these tasks year after year. They will figure out this plan and impose it on themselves on their own far faster and better than any lay outsiders ever could. Why? If one does not perform better than the competitors, one loses patients. If providers simply raise the cost on each patient, as providers do today, they accelerate the loss. In other words, in the new Buy Right market, providers will manage themselves, and purchasers can get out of the policing business entirely. That is the kind of managed care I think about, not today's policed care. It requires only that purchasers buy right.

Implications for Buy Right

Several points are worth noting. First, imagine trying to get this kind of innovation and reorganization — provider reform — by trying to micromanage and police providers under the old "buy wrong" incentives. Imagine trying to get a Honda out of General Motors by micropolicing parts and prices. Particularly, imagine trying to get a Honda out of General Motors if the policers have never seen one. Second, note the time requirements of the provider restructuring implied here. The providers and the plans of today are wholly organized for the old product, costliness independent of results. They cannot totally reorganize for the new product overnight. Under dire Japanese competition, Detroit has taken at least five years to reinvent their product, production processes, and organizational structure — Ford and the Taurus, General Motors and the Saturn, etc. — and they are still at it. Provider reform will take providers and plans no less time.

The reality means that savings from Buy Right in the first year or two will be dwarfed by the savings in five to ten years. Immediately, providers can only trim out some fat from their old style. But since they are doing so in their own interest, they are likely to be far more effective than today's policed care; consequently, even these early savings should be quite worthwhile. As they reorganize to integrate the care process for health results and economy and begin to innovate constantly, the real economies and quality improvement will emerge, and the savings will multiply strongly and steadily. If purchasers include patient back-to-work time and subsequent on-the-job functioning among the health results measured, they should also reap substantial indirect savings from downtime, as well as direct health benefits savings.

Finally, note that purchaser reform must precede provider reform. No provider reform can happen until sufficient numbers of patients are informed and have incentives to make providers change in order to keep patients. To be more accurate, no provider reform can start until providers are persuaded that a sufficient number of purchasers in their area will inform patients and provide them incentives. Purchasers need about three years to institutionalize the Buy Right process in an area. Purchaser reform is not quick or easy. Somewhere in this period providers become persuaded of purchasers' seriousness, and provider reform begins.

The Buy Right Principle

What a market strategy for health care cost and quality must do should now be clear. That strategy is the

Buy Right principle: Purchasers must reward efficient, high-quality providers and plans with patients at the expense of less efficient or effective providers and plans, by giving patients the two things they now lack for a sound market to work: (1) readily available, understandable information comparing the measured quality and costliness of providers and plans, and (2) means and incentives to choose providers and plans not only for quality but also for value.

The key is consumer information and incentives. First, we need information on quality: health results and patient satisfaction. I do not want to be locked into an HMO or a managed care plan. And I do not want my employer to choose one for me. Nor should an employer want the liability. I want to lock myself into a good set of providers who get great results and who care about me. But information is not enough. Consumer incentives for value must also exist. If we just give information, everyone will choose quality and ignore cost. But if we have to pay some part of the bill or, better, get some reward in savings or other benefits for our choices, we will look not just for quality alone but also for providers who do better for less. The patient shift, not information or policing, does the job on providers. Quality and efficiency spread because consumers concentrate at these plans and providers. Poor quality and costliness shrink because consumers desert such plans and providers; they shape up or go broke. And they all start to chase each other to stay ahead on quality and value.

Problems Implementing Buy Right

If Buy Right is so wonderful, why aren't all purchasers doing it? It is difficult and not at all obvious, even when one knows the principle. It has all kinds of pitfalls, and I have stepped into most of them. I am more convinced now than ever that it can be done, but only if it is done right.

The first thing everybody wants to know is whether we can really measure the quality of individual providers, and how we do that. Hard as that task is, an even tougher question follows: What do we do when we know that? To measure quality, we hire independent expert assessors. They do exist, albeit most of them are starving for lack of business now. Providers certainly do not hire them. The next question is then how to get providers to allow someone in to assess them. And how does one get them to change from business as usual. The managed care plans have not succeeded.

Well, we all chorus, we shift our beneficiaries to the good ones. Good answer, class. Now, that raises a tough enough little question in its own right: How do we make changes without provoking a major member revolt? Altering benefits or curtailing provider choice is a strike issue in some industries and a major employee relations problem in most. How do we install strong enough incentives for members to shift providers rather than axing employers?

Assume that we succeed. Then we are back to the really tough question, the matter of our leverage on providers. If every teacher in the school district began shifting providers, would that shift be enough to pressure providers to accept assessment or really change their ways? One might ask whether providers would raise a rumpus with teacher members in their clinics, with school board members on the golf course, with community leaders from distinguished hospitals who feel threatened. Another consideration is that many purchasers are companies selling products to providers and would not want providers to boycott their products. Remember that health care is a big market, one-eighth of the economy. Purchasers all over the country are trying to apply the Buy Right principle, many without much success. Implementing the principle has proven more complicated than many purchasers realized at first. Let's take the questions in order:

- How do we measure quality?
- How do we provide incentives for beneficiaries to shift happily?
- How do we leverage providers to come with us desirably and happily? The latter is the toughest question of all.

Assessing Quality of Care

Listening to providers, we hear that quality is so ineffable that only providers can hope to assess it, and even then only in moments of divine inspiration. Certainly it is hopelessly beyond consumers' understanding. The reason they respond this way is that their quality assessment methods are hopelessly archaic. Bell Laboratories wrote the book on modern quality assessment and control in the 1930s. The Japanese read the book. Now American industry is reading the book. American medicine has yet to read the book. If we implement Buy Right, I am certain that American medicine will read it.

I do not accept the view that the difficulty of assessing quality of care, difficult as that is, is what is holding us up. I also do not agree that we cannot do Buy Right without more research and development on assessment methods, although we should do so on the right kinds of methods. This thinking is backward. The provider literature is replete with methods that, for all

their limitations, are 100 percent superior to anything used by providers today. Remember the earlier tip about everyone doing the wrong thing. If nobody is using the available methods, do not suspect the methods; instead, suspect the macrosystem incentives. Right now providers have every incentive not to assess themselves. Assessment methods are weak because the incentives are bad, not vice versa. Change the incentives by Buy Right, and the methods will improve rapidly. Start by getting as great a percentage of patients and provider revenues under assessment as possible in order to establish the new system structure, then expand as fast as methods become available to more patients and dollars. We can reach at least 25 to 40 percent or more of patients and revenues with reasonable modern methods available right now. That is more than enough to get started. With growing demand for assessment, methods should improve rapidly, especially if we make assessors compete and persuade the federal government to push the right research and development now.

The most important point about modern quality measurement is that it is statistical, like a batting average. Suppose that we get a car that satisfies us in every way. Did we get a quality car? Only in the popular sense. In a precise, technical sense we only got a good result. Whether we got a quality car in the technical sense depends on what everybody else who bought the same make and model got. If they got the same good result we did, then we all got a quality car in the technical sense. Suppose they all got lemons. Then we did not get quality; we were just lucky. Quality is measured by comparing the ratio of desired results with all results on comparable patients. What we really want to know when we choose a provider is the batting average on patients like us. We do not want to know how the provider did with Mrs. Jones down the street. The provider may have been lucky or unlucky that day.

Consumers cannot measure quality from their own experience. As in baseball we cannot tell the quality of a hitter by going to a few games. We have to know his batting average. And how do we know that? Someone who sees the whole season has to tell us. The measures keep advancing. Batting averages are available for each player for runners in scoring position, for lefties, and so on. Then we can build up a good picture of a hitter's performance. In a similar way in health care, someone who sees every case of each provider and plan has to tell consumers their batting averages on each kind of patient and condition. We can keep refining those measures to build gradually a clearer and clearer picture of the performance of each provider and plan.

Let's look at an assessment system currently in operation. Any provider can buy this system today, but in the present market few buy, even though the maker is desperately trying to market it. With the system costs can be measured. For example, we can see a hospital's cost and complication rate for nonemergency gall bladder surgery. I should note that complications are not a great measure of health results. I would prefer to have measures of what happened to the patients in a year or two. For what percentage of patients did symptoms improve or worsen? However, the system does not collect that information yet, but it will if purchasers start to buy right. Right now we use a short-term measure, death and complication rates, because that is a meaningful short-term measure of results available now. After all, one dictum of medicine is, at least do no harm.

Comparative cost can vary more than 100 percent for the same procedure across different hospitals, a variation that is not unusual. And complication rates can vary even more, from a 1.9 percent rate of complication in one hospital to 9 percent in another. Doctors and hospitals try to argue away these differences by saying that patients vary in how sick they are at admission. Although true, this argument is often used as an excuse to do nothing about cost or quality. So we measure both. The measured admission severity of the gall bladder patients can be constructed from each patient's medical chart at admission and then be used as an index. We can then examine every variation and see what hospital is getting the most efficient results, with measurably lower complications on sicker patients at less cost than others. We can find great bargains — hospitals with superb results for half the cost of others with poor results. And we can find great disasters in results, in cost, or in both.

Such comparisons are not too mysterious for consumers to understand. Wouldn't we want to know this kind of thing if we have a loved one needing gall bladder surgery? My guess is that the fastest way to improve the quality and efficiency of hospitals would be to give consumers this kind of information, along with incentives to shift. Do not argue with the hospitals over costs or services. Do not pay them some fixed average price as Medicare does. Why pay more than they ask? Find out who is doing a good job for less and send them your business. We have to get busy measuring results and reporting them to consumers. Why should consumers not have as much information on their doctors, hospitals, and plans as they have now on cars and ball players.

Do not rely on providers' obsolete measures of quality. They are still trying to measure quality by the service, not the batting average on results. They use peer review; a panel of doctors looks at a sample of cases of each provider. This approach is like trying to measure the

quality of baseball hitters by having a panel of expert hitters stand behind the plate, watch each batter hit a few, and determine the quality of hitting by how the batter swings. Wouldn't we prefer to know the batting average? The peer review panel of doctors may find a clearly incompetent provider. What happens then? If the panel tries to get the incompetent doctor off the staff, he or she sues. At this point many medical staffs give up because the effort is taking too much time away from their own patients and income. And who needs a lawsuit? Even if they do succeed in getting the incompetent off the staff, he or she does not disappear from the system but just goes to another hospital more economically pressed and desperate to add physicians who will admit patients. What exists is neither quality assessment nor quality control.

Finally, do not make assessment, buy it. Assessment is an expert product, and most of the available systems have taken five to ten years to perfect. Numerous reasonable expert assessors are in operation and are basing assessments on patient health results, not on services. Bring them all in and let them show their wares; then pick the combination that makes the most sense. Choose the assessors and hire them, so that they know whom they serve. Do seek advice and counsel from local providers, but do not give them the final say. Don't let foxes guard the henhouse.

No one best way exists for the assessment of health care, but better and better ways will exist over time. Right now assessors are largely starving because providers do not buy their product. By creating many local markets for assessors, Buy Right will create a market for expert assessors, and assessment should improve rapidly from the competition for each community's business. This situation should improve methods better and faster than any state or federal monopoly assessment system.

Placing Incentives on Beneficiaries

Without discussing in detail incentives for beneficiaries to shift providers, I want to note that they need to be provided both the information and the incentives through the benefits program, including benefit design and administration. The fortunate point is that a wide variety of incentives exists to encourage shifting to efficient, high-quality providers. These incentives are both financial and nonfinancial, positive and negative. Each purchaser can choose any combination of these, so that usually a way politically acceptable to the beneficiaries exists. This point is especially true when they know (1) why they are doing it (communication with employees is essential) and (2) that all other purchaser groups in town are doing it too. Never put a cost or a reward on a consumer that the consumer cannot change by prudent choice; and always include a stop-loss beyond which no consumer must pay. The idea is not to shift cost to beneficiaries or to cut protection; instead, it is to provide them incentives, to reward the person who chooses well and to penalize the person who chooses without respect for cost. Why should other members bear the cost of one consumer's imprudent choice of plans and providers?

The Buy Right Implementation Principle

The toughest question is how to implement Buy Right, even when we know the assessment methods and incentive benefit methods we would like to use. The crucial reason so many purchasers are having trouble implementing Buy Right is that they overlook how little leverage on providers one purchaser has acting alone. They fail to recognize that health care (and therefore covered care plans, too), unlike insurance, is a local product, made and bought locally. The only leverage a purchaser has on a local provider is what percentage of that provider's patients the purchaser can influence to shift. Any purchaser, no matter how large nationally, rarely has more than 5 percent of any local provider's patients in an area. Most have a lot less. What can local providers do if only 5 percent of their patients buy for results and economy, but 95 percent still buy for costliness? They cannot afford to reorganize for efficiency even if they want to do so. So if only one purchaser tries to buy right in a town, nothing happens. That purchaser runs all the risks — to upset employees, to upset providers, to upset community leaders on the boards of threatened hospitals — and cannot leverage the real returns that are desired, providers reorganizing for productivity. At most the lone purchaser can get a few discounts.

If all purchasers in one local area decide to buy right, then all patients suddenly have incentives to shift for quality and efficiency. Providers and plans must alter for quality and efficiency or lose patients to those who already have it. Of course, the better providers cannot stand still; they will have to innovate to stay ahead. Once all the purchasers in one locality buy right, the providers cannot afford not to change. By going in a crowd, purchasers minimize their own risk. The more purchasers and patients who buy right in a town (purchaser reform), the more rapid and certain provider reform will be.

Notice that we do not have to buy right in every town at once to produce provider reform; Buy Right happens in one town at a time. For example, if we buy right just with all Cleveland patients, then Cleveland

providers have to change. What is happening in Pittsburgh or in Dayton makes no difference because Cleveland providers get their patients largely from Cleveland, not from somewhere else. The local Buy Right implementation principle is as follows: Buy Right is not implemented purchaser by purchaser but town by town. Purchasers must enlist the great majority of other purchasers in each of their locations to implement Buy Right together in a joint communitywide purchaser project.

Besides concerting purchasing power to gain leverage, another reason purchasers must get together a town at a time is that each local market, in which providers compete head to head, has to have a uniform communitywide assessment system; otherwise consumers cannot compare providers. Moreover, for accurate batting averages to be constructed, every patient of every provider must be included. Most purchasers do not have enough patients of any one provider to construct any kind of batting averages on providers. Finally, 27 different purchasers cannot impose 27 different assessment systems on each provider. Assessment is much too expensive and data intensive for that to be practical. Each community of purchasers has to come up with one assessment system to compare all providers and plans in its area.

Notice, however, that each community of purchasers can arrive at its own system. We do not have to judge providers in Cleveland on the same assessment system as Pittsburgh or Cincinnati. We only have to have the providers who compete head to head for the same patient population on one system. Cleveland patients only need to compare providers in Cleveland, not providers in Cincinnati, because they do not use Cincinnati providers. Do not be misled by research types who think that every provider in the United States or in a state has to be assessed on one system. They always think that way. Even many nationwide purchaser groups — companies, unions, associations — and insurers think that they must assess and provide incentives to all beneficiaries nationally in the same way. This attitude kills the flexibility they need to leverage local providers by joining with other local purchasers. Teachers should be cautious of inflexible nationwide insurance firms for this reason. National purchasers with several locations can assure quality and efficiency for beneficiaries simply by checking that beneficiaries in each location are getting good results according to the local communitywide assessment system chosen by purchasers in that location. The object of assessment is consumer choice and sound local health care markets, not research or false administrative simplicity.

The Community Buy Right Project — Bringing in Providers

The big question now becomes, How do we leverage providers to accept assessment by an outside expert assessor? The answer is to join with other purchasers and use the concerted purchasing power properly and to let providers in on helping to choose the assessors. The local Buy Right project must proceed in carefully ordered steps; otherwise, even concerted leverage will be compromised.

The first step is for purchasers to get their own house in order. A critical mass of local purchasers must be committed to a joint Buy Right project. For a purchaser to be committed, the chief executive office (CEO) must commit. Buy Right raises high policy issues for purchasers — employee relations, provider relations, and old boy relations. Only the CEO can commit the purchaser. Until that commitment is secured, no leverage exists. The critical mass means CEOs sufficient in numbers and in stature for purchasers and providers alike to see that Buy Right is going to happen and to feel that they better get on board. Recruiting organizations never stops. The group must include champions — individual leaders of great stature committed to see the process through. Organizations do not have staying power; champions do. They will keep the organizations moving. That situation exists in Cleveland. Along with 10 to 15 people of similar stature and influence, John Morley, CEO of Reliance Electric Company and respected member of the community, intends to see this project succeed.

The second step is for all purchasers to start implementing incentives in their benefits. Providing incentives in benefits accompanies or precedes quality and efficiency assessment. If providers do not see purchasers solving the employee relations problems, they will know that patients cannot really be shifted. Then they will ignore Buy Right. Certainly, installing incentives cannot be made contingent on providers agreeing to assessment, as has happened in some cities. In that case talk will go on forever.

The third step is to meet with providers to inform them of the intentions. This step climaxes when purchasers finally call a meeting in which their CEOs address providers. Purchaser strategy here is critical for leverage. First, CEOs lead with quality, not cost. They must have quality care for employees because the down time of skilled employees is costly. Then and only then do they mention that they must have quality care at reasonable cost. Second, they state their approach, that purchasers intend to measure provider quality and cost and then help

employees shift to the better providers and plans that cost less. Providers can hardly quarrel with this approach, precisely because of its emphasis on quality. Third, they identify the methods they propose to use, methods based on polls, claims analysis, and other data sources not dependent on provider-held data. Although rather crude, this kind of assessment cannot be prevented by providers. Fourth, they announce the starting date of the project. This announcement creates finality and urgency. Finally, they state their own major concern, the crudeness of the assessment methods. They invite providers to join with purchasers immediately on a task force to come up with better assessment methods. They state that if the joint task force can convince the purchasers of superior methods before the starting date, the new methods will be used instead. If the decision comes after the starting date, the cruder methods will be used and will be changed only when the task force persuades them. If providers do not wish to join the task force, the project will proceed with the cruder methods, but purchasers would much prefer provider counsel and participation.

This posture gives providers no say about whether the project will proceed. It only allows providers to participate to improve the assessment methods. Faced with purchasers representing so substantial a percentage of their patients, most providers prefer to be in rather than out. Since the purchasers, not the task force, have final say on the methods adopted, providers have little way to stall the project. All they can do is to help arrive at better, fairer methods before the starting date. Better methods all rely on access to provider-held data, of course with patient confidentiality safeguards. If the task force agrees to these methods, the providers have committed themselves to allowing the outside assessors to have access to the necessary provider data.

Most providers want to do a good job. They see how poor the present system of policing prices and services is becoming, and they see, with some educating, that Buy Right is likely a better way. If their task force with purchasers agrees on the best methods in lieu of the cruder methods, and if purchasers accept, most providers will agree to the assessment. If some still refuse the better assessment, the process and the many participating providers now legitimize purchasers placing strong consumer disincentives against these providers, on grounds that their quality and efficiency are suspect. A $1000 deductible, for example, may help most of them see the light of accepting assessment.

More steps, more work, more pitfalls exist. Nevertheless, purchasers in Cleveland have used the above steps to win the participation of their local doctors and hospitals. They have chosen several assessors and are looking at others. Providers are now installing the systems. Results will be kept confidential until the bugs are out and then will be publicly reported, probably late in 1991. A year into the project, Cleveland appears well on the way.

We can easily see that Buy Right is no quick fix. The quick fixes have all been tried for 10 years and found wanting. Buy Right is the least complex purchaser strategy that will actually work permanently to contain cost while improving care and coverage. I hope teachers will give it a long, hard look and then get cracking. The Center for Policy Studies would welcome inquiries.

Toward the National Strategy

I shall close with recognition of the interest teachers take in national health insurance. I think Buy Right gives us a handle on an entirely new and better approach to national health insurance. Once one town installs and refines Buy Right, it can spread to a dozen, to 20, 50, 200, 300 other communities. In five years every community in the country could be embarking on Buy Right and learning from the initial pioneers, if we foster that growth aggressively. Once we have system reform going in a community, we can provide a pool for the uninsured in that town without being eaten out of house and home by cost escalation. In five years the whole country can be engaged in Buy Right system reform and these pools. We can then pass national health insurance legislation to make sure that everybody is included, that no one falls through the cracks. We build it right —system reform first, then coverage. We start in a few towns and get it right as we expand, until we finally have nationwide system reform and universal coverage for all. Thus, every time teachers help extend Buy Right to another town, we are not only solving our cost and quality problems, we are helping the nation move to superior care and coverage for all Americans at a cost we can afford. That is something worth fighting for. The teachers in communities across our nation can make a powerful difference.

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